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Africa's Expanding Population: Old Problems, New Policies

By Thomas J. Goliber

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Abstract—Sub-Saharan Africa faces an historic challenge: to achieve economic and social progress while experiencing extraordinary population growth. With an estimated 1989 population of 512 million, the 42 countries of sub-Saharan Africa have the highest birth and death rates of any major world region. While death rates have fallen since the 1960s, persistently high birth rates yield annual growth rates above 3 percent in many countries. The United Nations projects that the region's population will increase 2.7 times by 2025—to 1.4 billion.

Throughout the region, population has outstripped economic growth since the mid-1970s. In addition, many African countries are experiencing an epidemic of AIDS (Acquired Immune Deficiency Syndrome). The extent and demographic impact of the epidemic still are unknown, but disturbing social and political effects are already being felt.

The region's population growth will slow only when African couples begin to have fewer children. The average number of children per woman ranges from 6 to 8 for most countries. The Africans' preference for large families is deeply rooted in the culture and fed by the perceived economic benefits they receive from their children.

Economic stagnation during the 1980s prompted many national governments to recognize that rapid population growth was hindering their socioeconomic development. The political climate has shifted away from pronatalist or laissez-faire attitudes toward official policies to slow population growth. The policy formation process—detailed here for four countries (Zambia, Nigeria, Zaire, and Liberia)—is ponderous and beset with political and bureaucratic pitfalls. However, policy shifts in more and more countries combined with evidence of increased contraceptive use and fertility downturns in a few countries give some hope that the region's extraordinary population growth may have peaked and will start a descent. Whatever the case, the decade of the 1990s will be crucial for the future of sub-Saharan Africa.

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World Bank/Kay Muldoon

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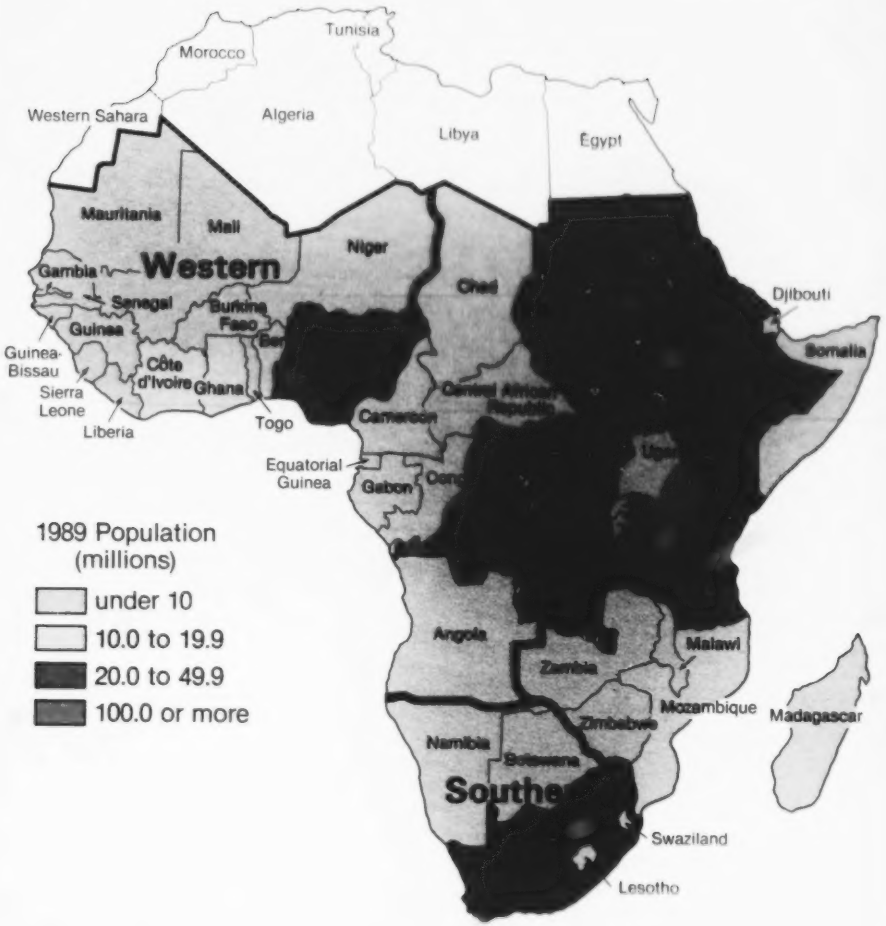
Figure 1. Sub-Saharan Africa



Note: No countries fall in the 50-99 category. Nigeria's 1989 population is estimated to be 109 million, 21 percent of the region's total number.

Africa's Expanding Population: Old Problems, New Policies

By **Thomas J. Goliber**

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Dr. Goliber would like to thank his colleagues at The Futures Group, the U.S. Agency for International Development, Carolina Population Center, John Short and Associates, Population Reference Bureau, Research Triangle Institute, and the World Population Society for their assistance in preparing this Bulletin. *He is grateful to his numerous African friends and professional counterparts who have contributed so much to his views on population issues in sub-Saharan Africa.*

Sub-Saharan Africa faces an historic challenge. Never before have so many nations tried to modernize in the face of such extraordinary population growth. The combination of rapidly growing populations and stagnating economies has made the issue of population and development in sub-Saharan Africa one of the great unfolding dramas of our time.

Geographically vast, culturally diverse, the 42 nations of sub-Saharan Africa contained an estimated 512 million persons in 1989. The region's population is increasing by nearly 3 percent per year, faster than in any other region on earth, and growth rates may not peak until the 1990s. The United Nations projects that nearly a billion persons will be added to sub-Saharan Africa between 1980 and 2025. Africa's population is growing so rapidly because birth rates are collectively the world's highest and, unlike the rates in other developing regions, have fallen only slightly while death rates have fallen significantly, though they are still high by world standards.

Severe shortages of basic goods and services in many sub-Saharan nations, and bleak prospects for future economic growth add to Africa's dilemma. Indeed, the continent gained world attention in the 1980s through appeals for emergency food relief to stem hunger and famine across the region. The crises of the 1980s only reflect longer term trends.[1] With rapid population growth combined with degradation of arable and pasture land, political upheaval, and governments' failure to support agriculture adequately, per capita agricultural production has been falling since the 1960s. Because agriculture is the region's largest economic activity, this has

Author's note: This essay is a successor to a 1985 *Population Bulletin* entitled *Sub-Saharan Africa: Population Pressures on Development*. Some material is borrowed from the earlier work. This *Bulletin*, however, is more than an update of previous themes. Two changes in particular have contributed to a new environment for population policies and programs in sub-Saharan Africa. First, governments across the continent are considering or have adopted official population policies to reduce fertility and high rates of population growth. Second, the rapid spread of AIDS in parts of Africa has brought a new dimension to the population discussion. Nonetheless, one major theme remains consistent—the effort to develop Africa socially and economically in the face of extraordinary population growth is one of the greatest challenges of the modern world.

hastened economic decline in an already impoverished region. After advancing by a healthy 3.7 percent between 1965 and 1973 (excluding South Africa), the gross national product (GNP) per capita in sub-Saharan Africa fell into a decline. By 1987, GNP per capita was well below its 1970 level.[2]

Africa–South of the Sahara

Sub-Saharan Africa covers about 20 percent of the earth's land surface, and, in the late 1980s, contained approximately 10 percent of the world's population (see Figure 1).

The population is diverse, with more than 800 ethnic groups speaking 1,000 different languages or dialects. In many cases, national boundaries do not correspond to the geographic distribution of major ethnic groups, creating serious political problems. Often, English, French, or Portuguese—the languages of the former European colonial powers—have been adopted as official languages and used in the schools and governments.

Economic situations are also diverse. Only about 13 percent of the region's population lives in the low-income, semi-arid and resource-poor nations such as Chad, Somalia or Rwanda. Over 60 percent live in countries such as Nigeria, Ghana, Sudan, Uganda, Zaire, and Zambia which have a resource base on which to build the development effort. Even in the resource-rich nations, however, economies have been sluggish, placing them among the poorest countries in the world.[3]

Sub-Saharan Africa includes a number of relatively small countries, partly a reflection of the historical ethnic diversity of the region, but also a legacy of the European "scramble" to establish African colonies in the 19th century. All but Ethiopia and Liberia are former European colonies which have only gained independence since World War II. Only 7 of the 42 sub-Saharan nations (including Madagascar but excluding the six smaller island nations—Cape Verde, Comoros, Mauritius, Reunion, Seychelles, Sao Tome and Principe), had 1989 populations greater than 20 million persons, according to UN estimates (see Table 1). Over 20 percent of the sub-Saharan population lives in one country, Nigeria, which had an estimated 1989 population of 109 million. Nearly 40 percent live in one of the other six relatively populous nations: Ethiopia (45.7 million), South Africa (34.5 million), Zaire (34.9 million), Tanzania (26.3 million), Sudan (24.5 million), and Kenya (24.1 million). By contrast, 17 countries contained fewer than 5 million inhabitants in 1989.

The economic and social setting of the region is still largely traditional. Most of the population lives in rural areas, eking out a living through subsistence farming. Illiteracy is widespread; death and sickness rates are high; women marry early; polygyny is common; families are large. Poverty is endemic, and it has worsened in recent years. During the 1980s, gross national product (GNP) per capita fell throughout the region as high rates of population increase have outstripped economic growth.[4]

Rapid Population Growth

From the limited data available, the United Nations judges that death rates have fallen slowly in recent decades while birth rates have remained high or even risen. As a result, natural increase—birth rates minus death rates—has mounted each decade. The region's natural increase averaged 2.6 percent a year in the 1960s, 2.9 percent in the 1970s, and in the late-1980s, about 3.0 percent a year—a rate that, if continued, would double the region's population in 22 years.[5] In contrast, in Asia, natural increase averaged about 1.9 percent a year in 1989, or 2.2 percent if China is excluded.[6] In Latin America, the 1989 average rate of natural increase was about 2.1 percent.

Table 1. Population and Vital Rates, Sub-Saharan Africa, 1989

	Population		Birth rate	Death rate	Natural increase	Infant mortality rate[a]	Life expectancy at birth	Total fertility rate[b]
	Estimated 1989	Projected 2025	(per 1,000 population)		(percent annually)		(years)	
	(millions)							
Sub-Saharan Africa	**512.0**	**1362.0**	**47**	**17**	**2.9**	**112**	**51**	**6.6**
Western Africa	**193.1**	**525.3**	**49**	**16**	**3.2**	**112**	**49**	**6.8**
Benin	4.6	13.0	51	19	3.2	110	47	7.0
Burkina Faso	8.8	22.7	47	19	2.9	138	47	6.5
Côte d'Ivoire	12.1	39.8	51	14	3.7	96	53	7.4
Gambia	0.8	1.9	47	21	2.6	143	43	6.4
Ghana	14.6	37.0	44	13	3.1	90	54	6.4
Guinea	6.7	15.7	47	22	2.5	147	42	6.2
Guinea-Bissau	1.0	2.2	41	20	2.1	132	45	5.4
Liberia	2.5	7.2	45	13	3.2	87	55	6.5
Mali	9.1	24.1	50	21	2.9	169	44	6.7
Mauritania	2.0	5.0	46	19	2.7	127	46	6.5
Niger	6.9	18.9	51	21	3.0	135	45	7.1
Nigeria	109.2	301.3	50	16	3.4	105	51	7.0
Senegal	7.2	16.4	46	19	2.7	128	46	6.4
Sierra Leone	4.0	9.6	48	23	2.5	154	41	6.5
Togo	3.3	9.5	45	14	3.1	94	53	6.1
Middle Africa	**67.5**	**179.6**	**45**	**16**	**2.9**	**107**	**50**	**6.0**
Angola	9.7	24.7	47	20	2.7	137	45	6.4
Cameroon	11.0	26.2	42	16	2.6	94	51	5.8
Central African Rep.	2.8	6.8	44	20	2.5	132	46	5.9
Chad	5.5	13.2	44	20	2.5	132	46	5.9
Congo	1.9	5.0	44	17	2.7	73	49	6.0
Equatorial Guinea	0.4	1.0	42	19	2.3	127	47	5.7
Gabon	1.1	2.9	39	16	2.2	103	52	5.0
Zaire	34.9	99.5	46	14	3.2	98	53	6.1
Southern Africa	**40.0**	**78.0**	**33**	**10**	**2.3**	**77**	**60**	**4.7**
Botswana	1.2	3.4	47	12	3.6	67	59	6.3
Lesotho	1.7	4.3	41	12	2.8	100	56	5.8
Namibia	1.8	4.9	44	12	3.2	106	56	6.1
South Africa	34.5	63.2	32	10	2.2	72	60	4.5
Swaziland	0.8	2.2	47	13	3.4	118	56	6.5
Eastern Africa	**211.6**	**580.2**	**47**	**20**	**2.7**	**115**	**50**	**6.7**
Burundi	5.3	13.1	46	17	2.9	112	49	6.3
Djibouti	0.4	1.1	47	18	3.0	122	47	6.6
Ethiopia	45.7	112.3	44	24	2.0	154	41	6.2
Kenya	24.1	77.6	54	12	4.2	72	58	8.1
Madagascar	11.6	33.0	46	14	3.2	120	54	6.6
Malawi	8.2	22.8	53	20	3.3	150	47	7.0
Mozambique	15.2	34.4	45	19	2.7	141	47	6.4
Rwanda	7.0	18.1	51	17	3.4	122	49	8.3
Somalia	7.3	18.9	51	20	3.1	132	45	6.6
Sudan	24.5	59.6	45	16	2.9	108	50	6.4
Tanzania	26.3	84.8	51	14	3.7	106	53	7.1
Uganda	17.8	55.2	50	15	3.5	103	51	6.9
Zambia	8.1	25.5	51	14	3.7	80	53	7.2
Zimbabwe	9.4	22.6	42	10	3.2	72	58	5.8

[a] Infant Mortality Rate = Annual deaths to children under one year per 1,000 births

[b] Total Fertility Rate (TFR) = Average number of children women would have by age 49 at the current age-specific birth rates. These rates are UN estimates. Recent Demographic and Health Surveys have recorded different TFRs in Botswana (5.0), Burundi (7.0), Kenya (6.7), Swaziland (5.2), Uganda (7.3), and Zimbabwe (5.7), among other countries.

Source: United Nations, *World Population Prospects 1988* (New York, 1989).

As we enter the 1990s, sub-Saharan Africa has the highest birth rates of any major world region. In Western Africa, the birth rate was an estimated 49 per 1,000 population and the total fertility rate—the average number of lifetime births per woman at current age-specific fertility rates—was 6.8 births per woman. Among the most populous Eastern African countries, the estimated birth rate was 44 in Ethiopia, 54 in Kenya, 45 in Sudan, and 51 in Tanzania. In Middle Africa, dominated by Zaire, the overall birth rate was 45 and the total fertility rate (TFR) 6.0 in 1989. Birth rates are markedly lower in the southern part of the continent, largely due to South Africa. South Africa's birth rate of 32 and total fertility rate of 4.5 were the lowest in the region (outside the island nations of Mauritius, Reunion, and the Seychelles).

There are two geographic belts of especially high fertility. One, in the eastern part of the continent, extends from southeastern Sudan southward into parts of Kenya and Uganda, continues through Rwanda, Burundi and part of Tanzania, then into regions of Zaire, Zambia, Zimbabwe and Mozambique. The other extends along the coast of Western Africa from the southern part of Nigeria to Côte d'Ivoire and northward through western Nigeria into parts of Niger and Burkina Faso.[7]

There is also a well-known band of persistently high subfecundity and infertility running across central Africa, due to high prevalence of such diseases as genital tuberculosis and especially gonorrhea. From 14 to 32 percent of women are childless at the end of their childbearing years in Cameroon, Central African Republic, Congo, Gabon, and regions of Zaire and Zambia, keeping birth rates below what they might otherwise be.

Average life expectancy for Africans is among the world's lowest. Estimated life expectancy at birth in 1989 was still below 50 years in just over half the countries of the region and only modestly above 50 in several others (see Table 1).

Nonetheless, the region's life expectancy has actually increased steadily since the 1950s, with the elimination of smallpox, for example, better control of epidemic diseases like yellow fever and malaria, and other medical and health improvements. Between 1950 and 1989, according to UN estimates, life expectancy rose from 37 to about 51 years in Cameroon and from 41 to about 58 years in Kenya.[8]

By 1989, with high birth rates combined with declining death rates, natural increase was about 3.2 percent a year in Western Africa, 2.7 percent in Eastern Africa, 2.9 percent in Middle Africa, and 2.3 percent in Southern Africa (see Table 1). Because death rates are expected to fall further, the UN projects a rise in natural increase in the 1990s in many African countries.

Youthful Population, Future Growth

The population of sub-Saharan Africa is extremely young, a result of the long history of high birth rates and, to a lesser extent, the more recent declines in infant and child mortality. According to UN estimates, at least 45 percent of the population is under age 15 in most African countries. Only in Gabon and South Africa is the percent under 15 less than 40. By contrast, 38 percent of the Latin American population, and 21 percent of the United States population is under age 15. In Ghana, typical of the region, an estimated 47 percent of its 1989 population was younger than age 15. In Kenya and Zambia a majority of residents are under age 15.

The youthful age structure constitutes an economic burden because an exceptionally large share of development resources must go to meet the immediate needs of the young. Education, for example, commands 20 to 25 percent of government expenditures in many African countries.[9]

The large proportion of children create a built-in momentum for future population growth. Even if fertility immediately drops to the "replacement" level of a little over two births per woman, births would still outstrip deaths and population would continue to grow for at least 50 years. If replacement level fertility were attained immediately, the region's national populations would still grow by another 80 to 100 percent through the momentum built into their youthful age structures.

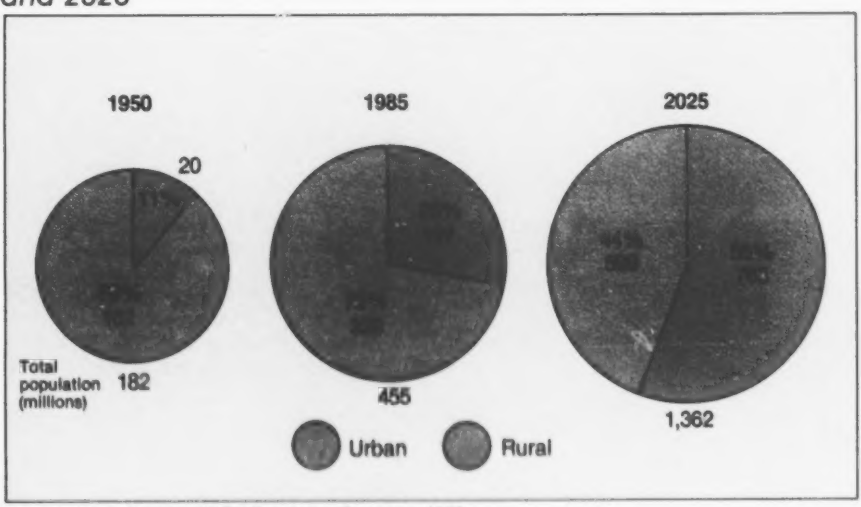
In reality, of course, reduction of present high fertility to replacement level will take many decades and national populations will continue growing for many more decades after that due to the built-in momentum. Barring extraordinary catastrophe, population growth will clearly be characteristic of Africa for at least the next century and probably beyond.

The UN projects that the sub-Saharan region will grow from 512 million persons in 1989 to 840 million in 2005 following the medium projection series. By 2025, the region's population could reach 1.4 billion. The medium projection series assumes that the region's total fertility rate will decline from 6.5 children per woman in 1985 to 5.5 in 2005 and 3.2 in 2025.

In the UN's high series, which assumes a slower fertility decline, to 6.0 children per woman in 2005 and 4.2 in 2025, the region's population reaches 885 million in 2005 and nears 1.6 billion by 2025. The UN low projection assumes a rapid fertility drop, to 4.7 children per woman in 2005 and 2.5 in 2025. Even here, the population reaches 813 million in 2005 and 1.2 billion in 2025.

Projected population increases for individual countries are even more dramatic. In the medium projections, Zaire's population grows from 34.9 million in 1989 to 57.8 million in 2005 and 99.5 million in 2025. Nigeria's population is projected to grow from an estimated 109.2 million in 1989 to 186.9 million in 2005 and to 301.3 million in 2025 according to the UN.

Figure 2. Urban Growth in Sub-Saharan Africa, 1950, 1985, and 2025



Source: United Nations, *World Population Prospects 1988*

Migration and Settlement Patterns

Moving to the Cities

The African population is distinctively rural. Only in the tiny nations of Djibouti and Equatorial Guinea, relatively prosperous South Africa, and Namibia do a majority of the population live in cities. But the region has been urbanizing at dizzying speed—fueled by a constant stream of migrants from the countryside as well as the high rate of natural increase in the cities themselves. The UN estimates that the overall urban population of the region increased six-fold between 1950 and 1985, from 20 million to 127 million. By 2025, the urban population could reach 763 million. The urban dwellers, only 11 percent of the 1950 population, now make up about 28 percent of the region's population and could reach 56 percent by 2025 (see Figure 2).

The number of cities with more than 500,000 inhabitants has also risen but in many countries, especially the smaller nations, a single, dominant metropolitan area—or primate city—has emerged. In

Table 2. Refugee Populations in Sub-Saharan Africa, Estimates for 1988

Asylum countries	Number of refugees	Source countries
Ethiopia	700,000	Somalia, Sudan
Sudan	693,000	Ethiopia, Chad, Uganda, Zaire
Malawi	630,000	Mozambique
Somalia	365,000	Ethiopia
Zaire	325,700	Angola, South Africa, Burundi, Rwanda
Tanzania	266,200	Burundi, Mozambique, Rwanda, Zaire
South Africa	180,000	Mozambique
Zimbabwe	171,500	Mozambique, South Africa
Zambia	149,000	Angola, Mozambique, Namibia, South Africa, Zaire
Uganda	125,500	Rwanda, Sudan, Zaire
Angola	95,700	Namibia, South Africa, Zaire
Burundi	76,000	Rwanda, Zaire, Uganda
Swaziland	70,700	Mozambique, South Africa
Rwanda	20,600	Burundi
Kenya	10,600	Ethiopia, Rwanda, Uganda
Source Countries		**Asylum Countries (Primary)**
Mozambique	1,147,000	Malawi, South Africa, Zimbabwe, Tanzania, Swaziland, Zamiba
Ethiopia	1,029,200	Sudan, Somalia, Kenya, Djibouti
Angola	395,700	Zaire, Zambia
Sudan	355,000	Ethiopia, Uganda
Somalia	350,000	Ethiopia
Rwanda	217,800	Uganda, Burundi, Tanzania, Zaire
Burundi	186,600	Tanzania, Rwanda, Zaire
Namibia	81,400	Angola, Zambia
Zaire	53,000	Angola, Burundi, Tanzania, Zambia, Sudan
Chad	41,300	Sudan, Cameroon, Nigeria, Benin, Central African Rep. Congo
South Africa	24,900	Angola, Swaziland, Lesotho, Zambia, Botswana, Zimbabwe

Source: U.S. Committee for Refugees, *World Refugee Survey—1988 In Review* (Washington, D.C.: American Council for Nationalities, 1989) pp. 32-34.

1985, 46 percent of Liberia's urban population lived in the country's largest city and capital, Monrovia. In Ghana, about 32 percent of the urban population lived in the Accra urban agglomeration. At the same time, 66 percent of Angola's urban population could be found in Luanda, all of Burundi's resided in Bujumbura, and about 32 percent of Malawi's urban population lived in Lilongwe, despite the newness of the city.

International Labor Migration

Africans have long been a migratory people. Swaziland and Lesotho were founded by Swazis and Basothos fleeing Zulu tribesmen. In the 19th century, Tanzania was settled by Bantu people from other parts of the continent. In recent decades, most international migration has been in search of better jobs—in the mines of South Africa, the hotels and factories of Nigeria, on the cocoa farms of Côte d'Ivoire. The major sending countries tend to be among the poorer, often landlocked countries of the African hinterland. Côte d'Ivoire, the most prosperous of the West African coastal states, Gabon and Zaire, Central African states with rich mineral resources and active mining sectors, and the Republic of South Africa, with its almost developed economy and great need for labor in the mines, are the major receiving nations. Sudan sends large numbers of workers to the oil-rich states of the Middle East.

The magnitude of such labor movements can be impressive. In the late 1980s, 51 percent of Lesotho's adult males were working in the mines of South Africa, a stark demonstration of virtual economic dependency on South Africa.

Refugee Movements

In addition to the labor migration, millions of Africans have been forced to flee their homelands in recent decades. Ethiopia and Mozambique, suffering from civil war and economic devastation, are the source of most of the region's refugees. By 1988, more than a million refugees from each of those two countries were living in other parts of the continent, according to estimates compiled by the UN (see Table 2). The countries that have received the most refugees are Sudan, with some 700,000 (mostly from northern Ethiopia), Ethiopia itself with about the same number from Somalia and southern Sudan, and little Malawi where about 630,000 Mozambicans, fleeing their war-torn country, have taken refuge. Overall by 1988, Africa had about 4 million refugees counted by the UN and undoubtedly hundreds of thousands more that do not show up in the fragmented official statistics.

In addition, several million Africans have been forced to move within their own countries because of military action or civil unrest. Statistics on this internally displaced population are even more elusive.

UNHCR/A. Hollmann

A refugee family from Mozambique finds temporary shelter in a refugee camp in Zimbabwe.

Rural Settlements

Over two-thirds of the population of sub-Saharan Africa lives in rural areas. The vast majority of these rural residents live in one of two distinct residential patterns. In the first pattern, common in much of Western Africa, people live in a central village and go out each day to work in surrounding fields. The other is a system of independent "smallholdings" scattered about the countryside, each occupied by a single, sometimes extended, family. The second pattern, characteristic of Burundi, Rwanda, and other East African nations, can hinder national development efforts because it is difficult to provide education, health, agricultural, and other services to a dispersed population.

Population Growth and Development

The social and economic development of sub-Saharan Africa is being hampered by the region's rapid population growth. Most visibly it constrains efforts to raise overall living standards, feed people adequately, preserve the land base essential for future development, catch up with the demand for jobs, education and health services, and cope with exploding cities.

Losses in GNP per capita

A high rate of economic growth does not necessarily mean widespread improvement in living standards, especially where national incomes are distributed unequally. On the other hand, when the population is growing faster than the economy, improvements in living standards are highly unlikely.

Most of the sub-Saharan region has witnessed a decade and a half of economic stagnation and declining living standards. Exclusive of South Africa, GNP per capita increased by a healthy average of 3.7 percent each year between 1965 and 1973. However, GNP per capita grew by only 0.7 percent per year between 1973 and 1980, and much of that growth was due to the oil boom in Nigeria. Except for 1985, the per capita GNP in the region declined every year between 1980 and 1987.[10]

Declining per capita Food Production

In sub-Saharan Africa in the early 1980s, hundreds of thousands died, and hundreds of thousands more suffered from severe malnutrition caused by one of the worst droughts in history. The rains returned in 1985 and 1986, but in some countries the rains brought an invasion of crop-damaging locusts.

In the 1960s, agricultural production kept pace with population growth. Since then, the region has become the only one in the world where food production is losing the race with population growth. During the 1970s, per capita food production fell by close to 1 percent per year. Then between 1981 and 1984, per capita food production plunged by 10 percent. Since then production has increased, but remains inadequate.

Several factors other than drought and rapid population growth have contributed to the food crisis in Africa. Frequently government policies depress food production rather than encourage it. Price controls have usually worked to the benefit of urban consumers and the detriment of rural producers. Heavy taxation on cash crops—coffee, tea, tobacco, and the like—along with mandatory marketing through government-controlled marketing boards have greatly restricted the growers' profits.[11] Political and military conflict—in southern Sudan, Somalia, Ethiopia, Mozambique, and elsewhere—have seriously disrupted farming. Tradition-bound agricultural practices, shortened fallow periods, and serious land degradation have also combined to keep productivity low.

Africa's main source of hope is that it is land rich. What little gain has taken place in agricultural production over the past 15

years has come mostly from increasing the amount of land under production, while yields per hectare have leveled off or declined.[12] A UN Food and Agriculture Organization (FAO) study in 1982, concluded that even using subsistence farming methods (no fertilizers or pesticides, traditional seed varieties, and no conservation efforts), enough cultivable land exists to feed indefinitely a population of about 940 million.[13]

However, on a country-by-country basis, the situation is less optimistic. The distribution of good land in Africa does not correspond to the distribution of people. In 1975, 14 countries—with about one-third the land area and one-half the entire sub-Saharan population—already were unable to maintain food sufficiency using subsistence-level farming methods. Many nations cannot afford the massive investments required to put new lands into production. If Africa is to increase food production enough to keep up with population growth, it would have to experience sustained growth in food production of about 3.5 percent per year, a growth record which has been accomplished by only a few countries in the world.[14]

Declining Land Quality

The region's expanding population has contributed to deforestation and desertification, undermining the ability of African nations to achieve sustainable development. Sustainable development provides for basic needs while at the same time preserving the long-term productive capability of the resource base. In present day Africa, the slow destruction of this resource base fundamentally threatens long-term sustainable development.

Forests are being depleted at a disturbing rate due to uncontrolled cutting, mostly for wood to be used for household fuel, and encroachment of farm settlements onto forest land. Some experts put deforestation at 50 acres a minute, and already at least 18 sub-Saharan African countries are facing acute shortages of fuelwood.[15] Deforestation contributes to

FAO/F. Botts

A West African clears an irrigation canal. Many African nations face a decline in per capita food production.

soil erosion, both because the soil is exposed and because crop and animal wastes formerly used as fertilizers are burned for fuel in place of wood.

Deforestation—which allows wind to strip the land bare of topsoil—is one of the factors in the relentless desertification taking place in Africa, especially in the Sahel region bordering the Sahara Desert. But overgrazing is also important in this loss of at least marginally useful land to permanent desert. The UN Environment Programme estimates that overgrazing, along with deforestation and poor farming practices, is turning 24,000 square miles of African land into desert each year.[16]

Labor Surplus

The imbalance between available jobs and workers is one of the most fundamental development issues facing Africa. The International Labor Office (ILO) projections indicate that the labor force* of the 42 sub-Saharan African countries is likely to grow from 186 million in 1985 to 368 million in 2010, and 574 million in 2025.[17]

Africa already has a labor surplus, indicated by widespread underemployment and unemployment. The Economic Commission for Africa estimated in 1983 that 40 percent of sub-Saharan Africa's entire labor force, about 64 million workers, was affected by rural underemployment.[18] By 2008, 71 percent of the rural labor force could be underemployed, according to these projections. At the same time, there are shortages of seasonal and highly skilled workers in some areas.

Many African nations strived to achieve universal primary school enrollment after independence. Ironically,

UNHCR/H. Gloaguen

A South African refugee in Swaziland learns a new trade. Workers with some skills are in short supply.

the improvements in educational attainment have only aggravated the labor situation. Among Africans, education is seen as the path to a better job. During the colonial era this was true: those fortunate enough to receive a primary school education could count on jobs as clerks or assistants in businesses or government. It was widely accepted that primary school "leavers" (graduates) had access, even a right, to jobs in the modern sector of the economy.

In the 1980s, there are more primary-educated Africans than the labor market can absorb, but this has not discouraged Africans' thirst for education. On the contrary, the demand for education appears to increase as employment prospects worsen. Education is seen as the escape from the tedium and poverty of traditional rural life. Obtaining a modern job is not assured, but the rewards are large for those who do. Those who fail are forced

*The labor force includes all men and women aged 15-64 who are working or looking for work. "Labor force participation" is a developed-country concept difficult to apply to the rural economies of sub-Saharan Africa. However, projections illustrate the tremendous future demand for new jobs.

into informal jobs in the cities or back into traditional, often subsistence-level, jobs in the countryside. The frustrated aspirations of huge numbers of young people who cannot find jobs after they leave school eventually may escalate social and political demands.

Education

African governments made strong financial and policy commitments to education after independence. Primary school enrollments increased impressively as a result.

This educational progress began to falter in the 1980s as education had to compete with other investments for its share of a shrinking pool of government funds. Between 1972 and 1987, the proportion of central government expenditures devoted to education fell from 15.8 to 10.8 percent in Malawi; from 19.0 to 8.3 percent in Zambia; and from 22.4 to 15.5 percent in Lesotho. Net primary enrollment rates (the percentage of school-aged children actually enrolled) have fallen in some countries. In Tanzania, the rate fell from 60 to 52 percent between 1983 and 1986; in Somalia, it fell from 25 to 14 percent between 1980 and 1985.[19]

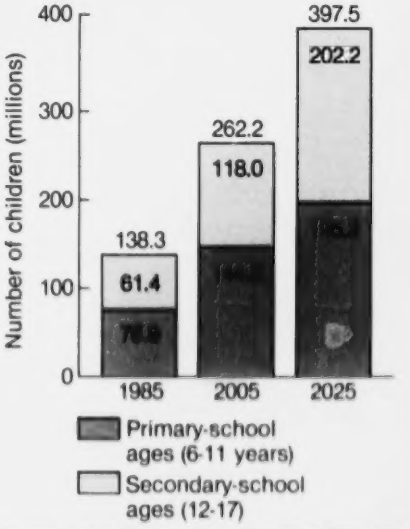
The goal of universal primary school enrollment will become more elusive as the numbers of primary-school-aged children escalate in the coming decades. The UN medium projections for the region show the number of children aged 6-11 increasing from 76.9 million in 1985 to 144.2 million in 2005 and 195.3 million in 2025 (see Figure 3).

Enrollments in secondary school have made more modest gains. In 1985, secondary students comprised only 20 percent of the population aged 13-18 in the Sudan, 12 percent in Ethiopia, and 5 percent in Burkina Faso. University education is available only to an even more privileged elite. Besides shortages of qualified teachers and facilities, higher education enrollments are kept low because of the scarcity of suitable jobs for these graduates in present-day sub-Saharan Africa.

Girls are still much less likely than boys to have access to schooling, but their enrollment rates have also soared since independence. Between 1970 and the mid-1980s the percentage of primary-aged girls enrolled in school rose from 7 to 22 percent in Burkina Faso, 33 to 40 percent in the Central African Republic, 14 to 53 percent in Gambia, and from 65 to 88 percent in Swaziland (see Table 3). However, in Mali, Lesotho, and a few others, net enrollment of girls dropped or remained constant.

In other parts of the world, increases in female education have been associated with a preference for smaller families and lower birth rates. In sub-Saharan Africa, however, few women stay in school more than a few years, apparently not enough to overcome the strong cultural bias toward large families. As educational levels continue to increase with succeeding generations, it is very likely fertility will eventually begin to fall.

Figure 3. Projected Growth of School-Age Children, Sub-Saharan Africa, 1985 to 2025



Source: United Nations, *World Population Prospects 1988*.

Table 3. Improvements in Primary School Enrollments, Sub-Saharan Africa, 1970s, 1980s

Country	Year	Percent of primary-school-aged children enrolled in school			
		Around 1970		Around 1985	
		Male	Female	Male	Female
Western Africa					
Burkina Faso	1970/1986	12	7	38	22
Gambia	1970/1985	30	14	84	53
Guinea-Bissau	1975/1984	36	32	71	35
Mali	1970/1984	20	12	19	11
Niger	1973/1985	17	9	35	19
Togo	1970/1986	77	35	88	58
Eastern Africa					
Kenya	1975/1980	86	79	88	84
Malawi	1973/1985	41	31	48	43
Mozambique	1972/1986	53	28	52	44
Rwanda	1973/1986	61	51	65	63
Somalia	1975/1985	25	17	19	10
Tanzania	1975/1986	53		51	53
Zambia	1976/1984	88	78	89	85
Zimbabwe	1986	—	—	100	100
Middle Africa					
Central African Republic	1970/1986	64	33	63	40
Zaire	1970/1983	79	51	86	65
Southern Africa					
Botswana	1973/1986	47	56	85	93
Lesotho	1970/1984	56	87	62	82
Swaziland	1970/1987	64	65	84	88

Source: UNESCO, 1988 and 1978-1979 *Yearbooks*.

Inadequate Health Systems

The average life expectancy for sub-Saharan Africans in the late 1980s was only 51 years. High infant and child mortality are the primary reason for the region's extremely low life expectancy. Deaths to infants under age one average more than 100 per 1,000 live births in 30 of the 42 sub-Saharan nations. By contrast, infant mortality rates in the United States, Canada, and Western Europe usually range between 7 and 10 infant deaths per 1,000 births. In many sub-Saharan African countries, deaths to children under age five make up more than half the total of annual deaths; in developed countries their share is 1 to 3 percent.[20] Maternal mortality rates are also high: 2 to 6 deaths per 1,000 live births—100 to 500 times the rates in developed countries.

The chief causes of illness and death are infectious diseases such as tuberculosis, malaria, measles, onchocerciasis (river blindness), trypanosomiasis (sleeping sickness), and tetanus; intestinal infestations like hookworm; and, among infants and children especially, diarrhea and consequent dehydration, and malnutrition.[21]

Better diets, better sanitary practices, and better health care could potentially bring death rates plummeting. UNICEF

(United Nations Children's Fund) began a campaign in 1982 for four basic low-cost measures that could halve child death rates in developing countries: oral rehydration therapy, a simple treatment to stop diarrheal dehydration; immunization against six major childhood diseases (known as EPI or Expanded Programme of Immunization); breastfeeding for at least six months and better weaning practices; and growth monitoring to enable mothers to detect malnutrition early. Child survival programs are now a keystone of international assistance in Africa.

The statistics suggest that health services have improved in most sub-Saharan African countries since independence. But most health professionals, hospitals, and other health facilities are located in urban centers, while most of the population lives in rural areas. Most Africans have very little access to modern health care.

Rapid population growth hampers the improvements in health and the delivery of health services in at least three ways. First, combined with economic stagnation, it is difficult to maintain, not to mention, upgrade services for growing numbers of people. Second, high birth rates create a high proportion of young children in the population—the group with the highest illness and mortality rates in developing countries and hence the greatest need for health services. Third, high fertility and closely spaced births are associated with high rates of maternal and child mortality.[22]

UNHCR/A. Hollmann

A woman and child visit a health clinic in Zambia. Most Africans have little access to health care.

Urban Crowding

Rapid urbanization has been characteristic of the region. In Nigeria, for example, the United Nations estimates that the number of urban dwellers increased nearly seven-fold between 1950 and 1980, from 3.3 to 21.8 million, and is projected to reach 68.9 million by 2000.

African cities are "plagued by the adverse effects of rapid growth—urban sprawl, unemployment, delinquency, inadequate social services, traffic congestion and poor housing," reads a statement from the Second African Population Conference, convened in Tanzania, January 1984. Some governments—Nigeria, Kenya and others — have adopted policies to slow or redirect this explosive urban growth. Such policies have not proved effective and are not a realistic alternative to dealing with the fundamental causes of rapid urbanization.

For millions of rural Africans, the possibility of a better life in the cities is an irresistible magnet. The fortunate few who find jobs in industry, business, or government earn incomes many times higher than they would in rural areas. Cities also claim the greatest share of modern social services—schools, health facilities, potable water, entertainment. Despite the squalor, lack of housing, pollution, congestion, and physical danger, urban centers still offer a glimmer of hope for a brighter future.

Demographic surveys in the late 1980s show that urban women in sub-Saharan Africa have fewer children than rural women, although urban fertility is still high. In Liberia, the total fertility rate for urban areas was 5.9, compared to 6.6 in rural areas. In Mali, the urban rate was 6.1, compared to a rural rate of 7.0.

Eventually, continued urbanization is likely to contribute to lower national birth rates.

An Emerging Crisis: AIDS

As if the current development crisis of Africa were not already desperate enough, levels of Acquired Immune Deficiency Syndrome (AIDS) in many sub-Saharan countries are among the highest in the world.

HIV Infection

AIDS is caused by a virus, known as the human immunodeficiency virus or HIV. This virus weakens the body's immune systems, rendering them unable to fight sickness, eventually leading to death. AIDS is usually transmitted sexually, though it may also be transferred through contaminated blood, unsterile needles, and from mother to unborn child or infant. However, several years, eight or nine on average, may pass before an HIV-infected person actually develops the disease. Although AIDS has not been studied long enough to know for certain, it is thought that at least 75 percent of those with HIV infection will contract AIDS. Among those who develop the disease, the fatality rate may reach 100 percent. Most AIDS victims die within two or three years.[23]

A graph of the AIDS population looks something like an iceberg. Those who have the disease are the part of the iceberg above the water. But the much larger and deadlier part of the iceberg is composed of those who are HIV infected but who have not yet developed the disease. This concept is important to grasp because the number of estimated AIDS cases in African countries (about 100,000 by mid-1988) appears surprisingly low for the publicity given the issue. What must be kept in mind is that the number of cases possibly represents 5 percent or less of those who are already HIV infected and that the number of persons infected is increasing rapidly.

Origins

In truth, not much is known about the origins of the AIDS virus; nonetheless, the origins issue is politically contentious in Africa. African health and political leaders often feel that Africa is being held responsible for starting the worldwide AIDS epidemic. Indeed, some observers have suggested that the high prevalence of AIDS in central Africa is strong evidence that the disease originated there. When African green monkeys were found to carry a similar virus, some researchers thought that the source of the disease had been found. Subsequent research has indicated that the green monkey virus is probably a cousin to the HIV virus, rather than a direct antecedent.

In seeking to place the origins of AIDS in Africa, other scientists observe that research into special case histories and frozen blood samples show the disease already present in Africa in the 1960s. Some evidence shows the virus present in North America in the late 1960s as well.[24] The uncertainty of the actual origins of the AIDS virus is underscored by a 1987 World Health Assembly statement that HIV is a "naturally occurring retrovirus of undetermined geographic origin."[25]

AFRICA REPORT magazine quotes Dr. Gottlieb Monekosso, director of the World Health Organization's office in Brazzaville, on the uselessness of the debate: "When a fire is burning in your

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Note: This discussion pertains to HIV-1, which is the virus responsible for most AIDS both in Africa and throughout the world. However, a second, distinct AIDS virus, known as HIV-2, has also been discovered, primarily in West African cities. Prevalence rates for HIV-2 in West African cities are several times lower than the corresponding rates for HIV-1 in East African urban areas. Some inconclusive evidence suggests that HIV-2 may be less deadly than HIV-1.[26]

house, it's not the time to start asking who lit the match or who was smoking the cigarette."[27] However, Dr. Fred Sai, a native of Ghana, currently Senior Population Advisor at the World Bank, cautions: "Any approach to AIDS in Africa must not be one which makes Africans feel that they are to blame for introducing the disease or unwanted as possible disseminators of it."[28] He fears that such accusations will make African leaders reluctant to join an effective and comprehensive international effort against the disease. In fact, several African states had refused permission to researchers to publish or discuss results because of adverse publicity. The origins issue promises to remain a volatile one which easily arouses emotions and which may never be resolved.

Sexual Transmission

AIDS in Africa is different than the disease elsewhere in some key respects. Homosexual activity has been the primary way to transmit the disease in other parts of the world, including the United States, while in Africa (and the Caribbean) the transmittal of AIDS is primarily the result of heterosexual activity. Consequently, while in the United States and Europe, there are 16 male for every female AIDS victim, in Africa equal numbers of men and women are infected.

AIDS has spread more quickly in Africa than elsewhere, precisely because it is heterosexually transmitted. Almost every sexually active adult is in the at-risk population. Also, African populations may be more susceptible to the HIV infection because of the high prevalence of other infectious diseases, many of which also affect the immune system.[29]

Promiscuity also contributes to the spread of AIDS. Studies that compare AIDS patients and control groups show that the AIDS group had significantly more heterosexual partners and that men with AIDS had had relations with female prostitutes much more often than those without the disease. Surveys suggest that levels of sexual activity outside marriage are high in African cities, especially among young people though not necessarily higher than in other parts of the world.

John Caldwell, an expert on African population issues, argues that African sexual norms are in fact different than in other parts of the world and that AIDS control programs must take this into account. He cautions that "the sub-Saharan African population is not a morally backsliding Eurasian population that can be returned by exhortation and educational campaigns to a pattern of sex occurring predominantly within marriage."[30] African leaders bristle at the notion, implicit or otherwise, that Africans are more promiscuous or sexually irresponsible than other peoples. The issue remains contentious.

Individuals with untreated sexually transmitted diseases (STDs), such as syphilis, herpes, and especially gonorrhea are at a much greater risk of HIV infection. HIV is not automatically transferred when an infected person has relations with an unaffected person; indeed, if both are otherwise healthy, the odds are small that the virus will be transmitted. However, the genital sores brought on by STDs appear to be highly effective conduits of HIV.[31]

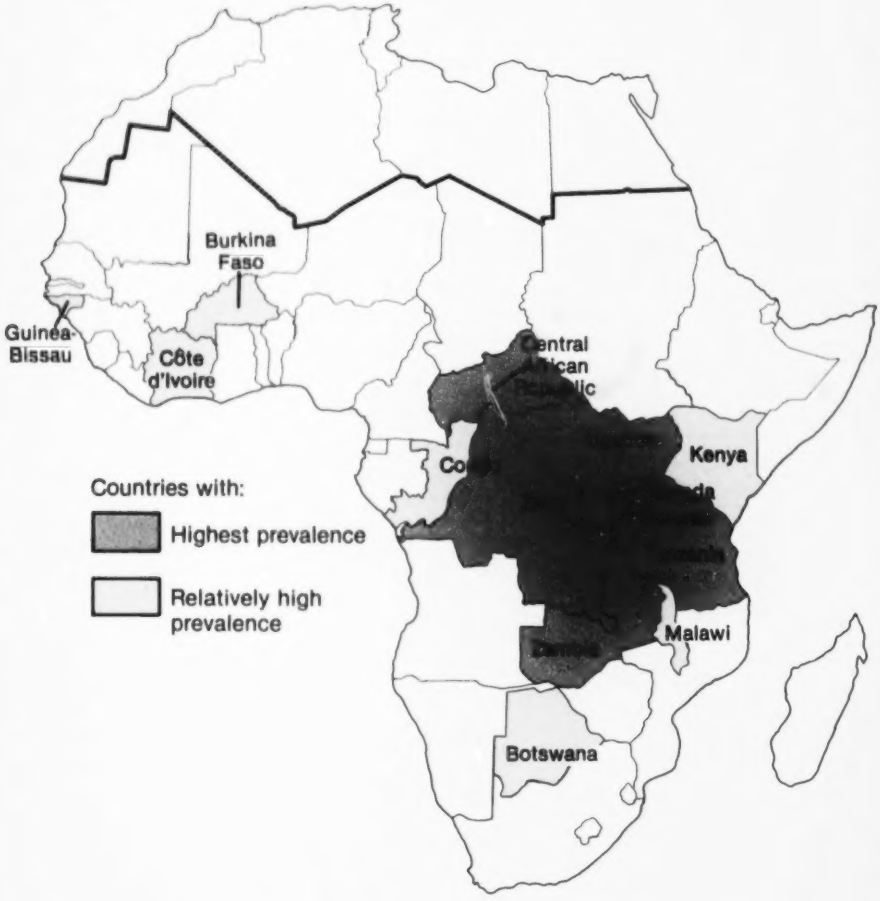
STD levels have long been high in this part of the world. For example, the estimated rate of gonorrhea per 100,000 persons in the early 1980s was 10,000 in Kampala, Uganda and 7,000 in Nairobi, Kenya, but only 310 in London, England. The combination of many sexual partners and the presence of a sexually transmitted disease provide optimal conditions for the transmission of AIDS.[32]

Some anecdotal evidence suggests that STD levels are declining in the parts of Africa most affected by AIDS. If this is true, some hope exists that the spread of the HIV infection will slow down.

Geographic Concentration

In the 1980s, levels of HIV infection and AIDS were highest in seven countries—Central African Republic, Zaire, Zambia,

Figure 4. Sub-Saharan Countries with High Prevalence of AIDS, 1980s



Source: Chin, James, et al., "A Global Response to AIDS," *AFRICA REPORT*, 33 (November-December 1988) p. 14; Heise, Lori, "AIDS: New Threat to the Third World," *Worldwatch* (January-February 1988) p. 25.

Tanzania, Burundi, Rwanda and Uganda—referred to as the AIDS belt. Scattered evidence also indicates relatively high levels of HIV infection in neighboring Congo, Kenya, Malawi, and Botswana, as well as in Guinea-Bissau, Burkina Faso, and Côte d'Ivoire in West Africa (see Figure 4).

AIDS in Africa is overwhelmingly a phenomenon of the urban areas and the transport routes between the cities. HIV prevalence rates are estimated to be 10 to 20 times higher in the cities of the most affected nations than in the countryside.[33] Sexual practices are less restrained in the cities and along the truck routes than they are in the rural areas, particularly since high rates of rural-to-urban migration have disrupted traditional tribal values without replacing them with new forms of social control. Still, the very fact that African populations are predominantly rural has undoubtedly limited the spread of AIDS. On the negative side, many of the best educated and most productive Africans live in the cities, so AIDS can have a disproportionate impact on development. President Kenneth Kaunda of Zambia, for example, lost a son to AIDS. His open discussion of this tragedy was an important contribution to the evolution of AIDS control efforts in the region. The loss of skilled manpower, the high costs, both direct and indirect, and the disruption of families, all promise to slow further the economic development of the region.

Prevalence

For all the concern about AIDS in Africa, surprisingly little scientific knowledge is available as to its extent. Regardless of the concerns over adverse publicity, African governments must recognize the importance of increasing overall knowledge of the workings of AIDS in the region, as a critical component of a control program. To some degree, the situation is improving. Uganda, for example, has recently completed a national sero-prevalence survey, the first of its kind in the region. The results are not yet available.

Most information on prevalence comes from surveys and tests, often among highly selective groups such as prostitutes, blood donors, or pregnant women. Nearly all the surveys are from urban areas or stops along the trucking routes. Summarizing these scattered sources of information in 1988, World Health Organization officials reported that from 5-6 percent of healthy blood donors, 25-30 percent of pregnant women, and from 27 to an astonishing 88 percent of female prostitutes tested HIV positive. For example, HIV infection rates among tested prostitute groups were 27 percent in Kinshasha, Zaire; 66 percent in Nairobi, Kenya; and 88 percent in Butare, Rwanda.[34] In a survey in Zambia's copper region, 10 percent of women at an antenatal clinic were found to be HIV infected. In Ndola, a town in that region, 13 percent of blood donors were found to be carrying the HIV infection. Overall, WHO roughly guesses that the number of infected persons in Africa may be 2 to 3 million. The number of actual AIDS cases is much lower, probably around 100,000 by mid-1988.[35]

The high prevalence of HIV infection among pregnant women in the urban centers of East and Central Africa is especially disturbing because the mother can transfer the AIDS virus to the child either before or after birth. World Health Organization officials express concern that hard-earned gains from child survival programs may be lost due to increased infant and child mortality from AIDS. Beyond directly caused deaths, the AIDS epidemic is also placing great demands on African health systems already under tremendous financial strain.

Demographic Impact

Beyond the personal tragedies, AIDS in Africa also raises critical demographic questions. Will mortality from AIDS reduce growth rates and disrupt the long-term pattern of rapid population increase? Or will AIDS be little more than a blip on the long-term demographic trend line? Will high mortality from AIDS depress the evolution of family planning programs in sub-Saharan Africa? Or will the increased use of condoms as an AIDS preventive serve as a boost for family planning efforts?

The long-term demographic impact of AIDS in Africa is an unknown. No benchmark and follow-up studies exist to determine how fast HIV infection is spreading. If expansion continues to be high in the urban areas and begins to

increase in the rural areas, then the demographic impact of AIDS could be severe.

John Bongaarts, demographer at the Population Council, has prepared a series of computer simulations on the course of AIDS in Africa. He finds that even without development of a vaccine to prevent AIDS or significant changes in sexual behavior, virtually all increases in HIV prevalence rates should occur during the first 25 years of the epidemic, after which a relatively stable state of equilibrium is reached. This computer simulation suggests that HIV prevalence will peak at somewhere between 20 and 30 percent of the adult population, *in the most severely affected countries and in the absence of effective medical interventions and substantial changes in sexual behavior.*

In this high threat scenario, population growth remains positive and rapid, though much less than it would be in the absence of AIDS. For example, if, in an Eastern or Middle African country, HIV prevalence rates rose from 0 to 20 percent between 1975 and 2000, and if the initial population growth rate were 4 percent per annum, then the growth rate in the year 2000 would be about 3.1 percent per year. At that rate, a national population would double in about 22 years. If the initial growth rate were 3 percent, the AIDS epidemic would reduce it to 2 percent by 2000. Thus, even in the high threat AIDS scenario, the populations of these nations continue to grow rapidly, though at lower rates.[36]

Education programs designed to change sexual behavior are at the core of AIDS prevention programs in African countries. Anecdotal evidence from such places as prostitute havens along truck routes, suggests that some of the highest risk sexual behavior is being modified already. If that is true and modifications in sexual behavior lessen the spread of HIV infection, then the demographic impact will be even less than indicated under the high threat alternative. Also, only between 7 and 10 of the sub-Saharan states have been substantially affected so far. Presumably, the demographic impact of AIDS in the more than 30 remaining countries, including such large states as Nigeria, will be much less. On the other hand, while the above simulation shows that prevalence rates peak about 25 years after the start of the epidemic, this may not happen. In that case, the demographic impact would be even greater than suggested.

AIDS projection models are being refined. Combined with new knowledge from sero-prevalence surveys, the models should contribute to a better understanding of the demographic implications of AIDS in Africa.

Effects on Family Planning

Some observers have expressed concern that rising mortality from AIDS could lead African governments to retreat from recently adopted policies to reduce fertility and population growth rates and to divert policy attention and resources away from family planning programs. Historically, family planning programs do succeed best in cultural settings where mortality is declining.

Condom use has risen dramatically in many sub-Saharan countries in response to AIDS. According to some reports, for example, the demand for condoms in Kenya rose from 10,000 per month in 1987 to 300,000 per month by the end of 1988. In Africa, however, condoms have ordinarily been used with prostitutes and extra-marital partners. For that reason, condoms used to prevent or control AIDS are not likely to have much effect on overall fertility levels.

Policy Options

Current wisdom is that no medical solution to the AIDS problem will be forthcoming before the end of the century. Viruses such as HIV have been known to mutate to benign forms on their own, but national policies cannot be predicated on such expectations. Policies must be based on public education campaigns to make people more aware of the dangers

of AIDS and explain the ways to prevent the disease, and on programs to make condoms more widely available. Ultimately, the general populace, particularly in the urban areas, must be persuaded to avoid high risk sexual behavior. This is a daunting task; critics note the inability of health education campaigns in general to change behavior.

The World Bank's Fred Sai argues against extreme pessimism. He points to the radically changing sexual practices of homosexual men in the San Francisco area as evidence that behavior can be changed. He urges African leaders to shed any remaining ambivalence about the seriousness of the AIDS problem and the need to mount urgent public education campaigns and to provide adequate condom supplies. "The aim," Sai concludes, "must be to provide hope, not panic; acceptance of a problem to be tackled, not apocalyptic doom."[37]

Determinants of High Fertility

Over the long term, fertility is almost certain to decline as Africa moves away from traditional societies toward a world of modern medicine, education, wage employment, and scientific farming. But for the present, a myriad of cultural and economic factors combine to keep African fertility the highest in the world.

Little Education; Rural Residence; Low Income

Africans are largely smallholding farmers who earn paltry incomes and have little, if any, education. Poverty, illiteracy, and a provincial rural lifestyle are associated with high fertility just about everywhere in the world. In sub-Saharan Africa these three factors help explain the persistance of many cultural beliefs and practices that keep birth rates so high. Some of these characteristics are common in most developing countries, others are uniquely African.

Low Status of Women and Need for Old Age Security

Although African women have traditionally played a major role in agricultural production, their primary roles are still seen as those of wife and mother. They have limited legal rights and in many places their status is further weakened by the practice of polygyny. Precisely because of the limited opportunities women have, the status imparted by childbearing assumes great importance. Demographer (and current Australian High Commissioner to Zambia) Helen Ware writes that "as mothers they wield considerable power and influence," adding that women's status could be weakened by a strong push to limit childbearing unless some new avenues for advancement are established.[38]

African women value children for their labor as well. With the arduous chores of primitive cooking and housekeeping, fetching water and fuelwood, and rearing large families added to labor in the fields, it is little wonder that women welcome assistance provided by children. C. Lwechungura Kamuzora of the University of Dar es Salaam argues that it is such economic underpinnings which support the high fertility regime in Africa, not religious or cultural values. Ultimately, he says, large families are desired because of the high demand for labor in African peasant economies and the need for economic security for women necessitated by their low status.[39] African women often may not own assets or inherit the use of land, so there is a particular need to produce many sons to ensure that some will survive to take care of them in old age.

Early Marriage, Strong Family Ties

Virtually all African women marry, usually at a young age. Women simply do not remain unmarried or childless by choice. Divorced or widowed women remarry

Table 4. Socioeconomic Indicators, Sub-Saharan Africa, 1980s

	Percent urban	Percent labor force in agriculture (females)	GNP per capita 1987
Sub-Saharan Africa	**28**	—	**440**
Western Africa	**28**	**74**	**380**
Benin	39	75	300
Burkina Faso	8	86	170
Côte d'Ivoire	43	75	750
Gambia	18	86	220
Ghana	32	52	390
Guinea	22	88	na
Guinea-Bissau	27	92	170
Liberia	42	87	440
Mali	18	74	200
Mauritania	35	87	440
Niger	16	94	280
Nigeria	28	69	370
Senegal	36	90	510
Sierra Leone	28	82	300
Togo	22	67	300
Eastern Africa	**18**	**90**	**240**
Burundi	5	98	240
Djibouti	74	na	na
Ethiopia	11	85	120
Kenya	19	86	340
Madagascar	22	94	200
Malawi	13	94	160
Mozambique	20	96	150
Rwanda	6	98	310
Somalia	33	90	290
Sudan	20	87	330
Tanzania	19	92	220
Uganda	9	89	260
Zambia	43	84	240
Zimbabwe	24	82	590
Middle Africa	**37**	**89**	**400**
Angola	25	89	na
Cameroon	42	78	960
Central African Republic	35	75	330
Chad	27	87	150
Congo	48	87	880
Equatorial Guinea	60	86	na
Gabon	41	88	2,750
Zaire	40	95	160
Southern Africa	**53**	**24**	**1,780**
Botswana	16	93	1,030
Lesotho	17	90	360
Namibia	51	51	na
South Africa	56	11	1,890
Swaziland	26	83	700

Source: Population Reference Bureau, *World Population Data Sheet, 1989*; International Labor Organization, *Economically Active Population, Estimate, 1950-1980, Projections: 1985-2025*, Volume II, Africa (Geneva: 1986); ILO *Yearbooks*, various years; *World Bank Atlas*, 1988.

quickly, a practice which is facilitated by the existence of polygyny throughout much of the continent. Consequently, African women spend nearly their entire

reproductive years at risk of pregnancy.

Once women marry, the large extended families help care for the children who promptly begin to arrive. In West African countries, some children live with a grandparent or other relative for at least part of their childhood—a practice called child fosterage. In Ghana, Liberia, western Nigeria and Sierra Leone, for example, at least 30 percent of the mothers use fosterage. Working women and non-educated women use fosterage more often than non-working and educated women; the practice is more common in the cities than the rural areas.

The fosterage system brings both social and financial rewards to the children's guardians, most commonly the grandparents. It is especially prestigious for a grandmother to have her grandchildren in the household, and remittances from the natural parents for child care provide a source of support for older persons. Fosterage is also used as a way to enhance occupational and educational opportunities for the children; it is also a means of accommodating, even benefiting from, the large numbers of children born to African families.[40]

Polygyny is still common throughout much of sub-Saharan Africa. An estimated 45 percent of married women in Mali and 38 percent in Liberia, for example, live in polygynous unions. Some surveys show that women in such unions have lower fertility than those in monogamous marriages. However the interpretation of such data is complicated by the fact that infertility is grounds for divorce and barren women often remarry into polygynous households where the husband can sire children by other wives. Women in polygynous marriages who are able to bear children have large numbers of them.

Marriage is often regarded as a contract between families, with reproductive rights belonging to the husband and his family. For example, among the Igbo of southeast Nigeria, the payment of bridewealth by a man gives him all rights over a woman and her children.[41] For many Africans, a wife who tries to control her own fertility threatens to arouse the ire of her husband's ancestors and to undermine sources of long-term economic support for her husband and his family.

Although many of the economic burdens of childrearing fall to the wife, ostensibly giving her a motivation to use birth control, her social and economic vulnerability may make her loathe to limit the number of children.

The psychological benefits of children cannot be overestimated in the African setting. Indeed, in a world marked mostly by the drudgery of subsistence agriculture, children and family provide the greatest psychological satisfaction in many lives. Conversely, infertility is regarded with abhorrence and can be adequate grounds for divorce. A barren women is usually regarded with open contempt and her infertility often considered a punishment for transgressions.

High Infant and Child Mortality

Infant and child mortality rates in sub-Saharan Africa are the highest in the world. In some countries between 20 and 25 percent of all children die prior to their fifth birthday. In these settings, parents want large numbers of children to ensure that at least some will survive to adulthood. And fertility *does* seem to drop modestly in countries when infant and child mortality declines. Drops in infant and child mortality alone, however, do not appear to cause sharp changes in fertility behavior.

A general rule sometimes used by demographers is that for family planning programs to succeed, life expectancy at birth must be above 50. In mid-1989, as many as 23 sub-Saharan countries still had life expectancies under 50 years; another 8 hovered close to that level. Cultural traditions die hard in peasant societies, even as external circumstances change. With mortality rates still relatively high, the days of high death rates and loss of children are more than lingering memories.

Pietronella van den Oever

African women play a major role in agricultural production, but their primary role is that of wife and mother.

Economic Support from Children

Children are expected to contribute substantially to their parents' well-being, especially that of their fathers and their lineages. Payment of tribute is expected from children, particularly sons, by parents or by members of the extended family in immediate need. Failure to meet expected obligations can not only bring exclusion from the affairs of the extended family, a serious sanction in African societies, but can also elicit the displeasure of the ancestors, living and dead. Angry ancestors can cause untold disasters and their wrath is to be avoided.

Transfers of wealth to relatives outside the nuclear family are probably higher in sub-Saharan Africa than in any other part of the world. Professionals are under especially strong pressures to share the rewards of modern sector employment with other family members. They do so and are rewarded with high familial status.

Parents, especially fathers, have a strong economic motivation to maintain high fertility. Education fees, health care and other expenses make children increasingly costly to raise. However, until the costs outweigh the expected returns, that is, until the transfers of wealth from the older to the younger generations exceed the anticipated tributes moving the other way, the economic underpinnings of high fertility will remain entrenched.[42]

Tribalism and Religion

Sub-Saharan Africa's great ethnic diversity tends to promote high fertility. Many Africans identify more closely with their tribe than with their nation, most of whose borders were established by European colonial powers without any

regard for ethnic groups. The smaller tribes are sensitive to their relative strength in the political order, which is believed to be related to numbers.

This jostling for tribal equality or supremacy in numbers happens to varying degrees in many African countries: among Hutu and Tutsi in Burundi; Shona and Ntebele in Zimbabwe; Yoruba, Igbo, Hausa, and Fulani in Nigeria, to mention a few examples.

Religion also affects Africans' views toward family planning. Large numbers of Africans still adhere to animistic beliefs based on a mystical, non-scientific view of the world. Planning the spacing and size of one's family may well not fit into lives thought to be dominated by supernatural forces.[43]

In many African societies, contributing to the immortality of the lineage by having large families is a fundamental religious responsibility which underlies high fertility regimes. In addition, bearing many children, along with abundant crop yields, is a sign of the gods' approval. Although two-thirds of sub-Saharan Africans are either Christian or Moslem, most still retain some belief in ancestral forces. These forces use their powers most often to ensure the survival of the lineage because the ancestors are expected to be reborn as descendants. Because belief in these ancestral systems remains so strong and persistent in sub-Saharan Africa, the resistance to fertility decline may be stronger here than in other parts of the developing world.[44]

More and more Africans are embracing Islam, which has further bolstered the preference for high fertility. Islam is not theologically opposed to the use of modern forms of contraception or planning of families, but as actually practiced in rural Africa it tends to value large families and restricted roles for women.[45]

Christianity is also expanding. Attitudes toward family planning and contraception vary widely among Catholics in Africa, as elsewhere in the world. Nevertheless, in countries like Burundi, the political influence of the Roman Catholic Church and provision of many health services through Catholic missions may be added impediments to a working population program.

Coping with Population Pressures

High fertility creates severe problems for African families. Smallholdings are fragmented in size; the land becomes less productive; education becomes costly and at times inaccessible; health care becomes harder to obtain. Yet the first response to the increased population pressure is not to lower fertility but rather to seek alternative ways to support the growing numbers of people.

For example, Kokou Vignikin reports that in southeast Togo the initial response of rural families is to intensify production—often at the cost of permanent damage to the soil—and to send family members to work in Lome, the capital, so they can send money to relatives back home. In this way, many Togolese families have been able to sustain high fertility despite increasingly limited land resources.[46]

Robert Levine noted that average smallholding size among the Gusii people of Kenya fell from 7 to 3 acres between 1956 and 1974 as both fertility and population size rose. Some Gusii migrated to less settled areas; others turned more to cash crops to augment family income; still other households became increasingly dependent on remittances from family members working in the cities and on the commercial plantations. Limiting family size was not chosen as an option. The Gusii, Levine notes, "have always looked to children for their economic, social, and spiritual security and tend to think of strategies for adapting to new conditions that include children rather than strategies that limit their number."[47]

Limited Contraceptive Use

In addition to the many cultural and economic factors encouraging high fertility in

Africa, the access to safe, effective contraceptive methods is quite limited. Fertility surveys completed since 1986 show that modern contraception was used by less than 4 percent of currently married women of reproductive age in Burundi, Togo, Uganda, Mali, and Senegal; only 5 percent in Ghana; and 6 percent in Liberia. In only 5 of the 20 countries for which we have survey data does contraceptive use exceed 15 percent of married women. Three of the five are in southern Africa (see Table 5). Modern contraceptive use rates in most non-African countries are much higher: for example, 18 percent in Bangladesh, 65 percent Thailand, and 45 percent in Mexico.

Despite low rates of usage, surveys record a high level of knowledge about modern contraceptives—70 percent or higher in most countries. Knowledge appears to have increased over the past decade, perhaps an indication that more women will begin using birth control. Actual use has increased markedly in a few countries as well. The percentage of married women using modern con-

Table 5. Contraceptive Knowledge and Use, Sub-Saharan Africa, Most Recent Estimates

		Percent of married women, 15-49			
				Current use	
	Year	Knowledge	Ever-Use	Any method	Modern method
Western Africa					
Benin	1981-82	40	34	9	1
Burundi	1987	78	30	9	1
Côte d'Ivoire	1980-81	85	71	3	1
Ghana	1988	79	37	13	5
Liberia	1986	70	19	7	6
Mali	1987	43	19	5	1
Mauritania	1979	8	2	1	0
Nigeria	1981-82	34	13	5	1
Senegal	1986	92	38	12	3
Togo	1988	96	74	34	3
Middle Africa					
Cameroon	1978	34	11	2	0
Eastern Africa					
Kenya	1989	93	45	27	18
Rwanda	1983	72	18	10	1
Sudan (North)	1978-79	51	13	5	4
Uganda	1988-89	84	22	5	3
Zimbabwe	1988-89	99	79	43	36
Southern Africa					
Botswana	1988	95	63	33	32
Lesotho	1977	65	23	5	2
South Africa	1980	—	—	48	45
Swaziland	1988	—	—	20	17

Modern methods include oral contraceptives, IUDs, male and female sterilization, injectibles, condoms, and other chemical or barrier methods.

Source: United Nations, *Levels and Trends of Contraceptive Use As Assessed in 1988*, Population Studies, No. 110, New York, 1989, Tables 2 and A.11.1; Institute for Resource Development/Macro Systems, Inc., *DHS Newsletter* (Columbia, MD: Summer 1989) p. 10.

Figure 5. Increases in Contraceptive Use: Botswana, Kenya, Senegal, and Zimbabwe

*Methods include oral contraceptives, IUDs, male and female sterilization, injectibles, condoms, and other chemical or barrier methods.

Source: United Nations, *Levels and Trends of Contraceptive Use*. 1989; *DHS Newsletter*, 1989.

traceptives increased from 4 to 18 percent in Kenya between 1978 and 1989 and from 27 to 36 in Zimbabwe between 1984 and 1989 (see Figure 5).

A Paradox

Africans have large families because they want them and perceive them to be in their economic and personal interest. High infant and child mortality, poverty and limited economic opportunities, insecurity, and restricted access to education mean that African couples' choice of large families is reasonable.[48] Yet large families and consequent rapid population growth are detrimental to the social and economic development effort in many African countries, thus negatively affecting most families.

Along with this paradox at the individual level, there is a vicious circle at the public level. Ultimately poverty and limited opportunities cause a gap between public and private interests, between the need to slow population growth to advance development and the desire for large families. It is the alleviation of poverty and increased social and economic opportunities that will close the gap. Yet the rapid rates of population growth make it increasingly difficult for African nations to reduce poverty and improve the lives of the people.

Barriers to Population Policy Formation

The key to closing the gap between public and private interests, as experience in other developing countries has shown, is the development of explicit population policy and political commitment to population programs. Yet in the 20 to 25 years following independence (in the late 1950s and early 1960s), population policy received little attention from African leaders.

Lack of Political Concern

Eager to pull their new nations into the modern world, most post-colonial African leaders focused first on the most productive aspects of economic and social development and foreign assistance.[49] Population growth was not a concern. Moreover, much of the pressure to reduce population growth was suspect because it came from Western aid donors. Many Africans were concerned that an emphasis on population policy would gloss over inequalities in the world economic order which they considered the real root of the region's poverty and underdevelopment.

Similarly, many Africans viewed population programs as family planning services only and insisted that social and economic development, not family planning programs, would eventually lower birth rates.

Leaders in the new states were cautious about delving into population issues. Religious and tribal rivalries made population and family planning programs politically sensitive. And, like politicians everywhere, they focused their attention on short-term issues for which they would be held politically responsible rather than longer-term issues which demand some vision of the future.

Also, African leaders lacked reliable data to understand fertility levels and to demonstrate how fast the population was growing. Most nations had not taken a census or major survey before the 1960s.

Accommodation to Growth and Other Factors

Africa, at the time of independence, had a small population relative to the size of its resource base. When population growth *rates* increased impressively with the fall in death rates after World War II, the actual *number* of people added each year was still relatively small and easily accommodated within the existing economy. Until the mid-1970s, the economies were growing fast enough to raise incomes and living standards even with rapid population growth.

Other factors discouraged the formulation of policies to limit population growth, such as the legacy of the French pronatalist intellectual tradition. In the African micro-states, the small internal market and the absence of international trade agreements have discouraged economic development. And the vast physical size of the continent creates an illusion of rich resources ripe for exploitation. The vastness belies the fact that much of the empty land is of marginal usefulness.

World Bank/Ray Witlin

Zambia

Zambia is a high fertility, high population growth rate country. The 1980 Census indicated a fertility rate of about 7.2 children per woman and a population growth rate of about 3.4 percent per year. In 1989, the annual growth rate was an estimated 3.7 percent, a rate at which the population would double in less than 19 years.

Historically, attitudes towards population growth among Zambian leaders have ranged from pro-natalist to laissez-faire. Zambia is a large country (about 750,000 square kilometers) with a relatively small population (about 8.1 million in 1989). Population policy simply was not a priority issue in the decades following independence.

As in much of the rest of Africa, the mid-1980s witnessed marked changes in attitudes in Zambia. The release of the 1980 Census results in 1985 provided statistical evidence of the high levels of fertility and rapid population growth. The economy, dampened by a stagnating copper sector, was in decline. Income per capita was lower in the mid-1980s than it had been at the time of independence. Maize production was lower in the mid-1980s than it had been in the mid-1970s. Many doubted the nation's ability to provide adequate education, health, and other social services to a rapidly growing population.

Zambia is illustrative of the African trend. Rapid population growth *in combination with a stagnating economy* has been the key to shifting attitudes. Previously the population issue had been considered primarily in terms of relating the current size of the population to some abstract potential carrying capacity, but by the mid-1980s population policy was being debated in terms of the effect of the projected size and rate of growth of the population on the country's ability to achieve its development goals.

Accordingly, the government of Zambia, headed by President Kenneth Kaunda, one of the few independence leaders still serving as head of state in an African country, instructed the National Commission for Development Planning (NCDP) to consider a national population policy. The NCDP organized a National Seminar on Population and Development Policy in December 1985. Representatives from government ministries, from private organizations such as the Planned Parenthood Association of Zambia and the Family Life Movement of Zambia, and from other important institutions such as the Christian Council of Zambia, were invited to attend. The mandate of this meeting was to consider national population and development policy and to make recommendations for consideration by the President and the Central Committee.*

The seminar recommended that Zambia's government and the one political party (UNIP) adopt a policy to lower the fertility rate and the rate of population growth. The explicit justification was that the high growth rate was detrimental to the social and economic development effort and that reducing the rate would help Zambia regain its development momentum. The National Seminar on Population and Development Policy designated child spacing and family planning programs as the primary strategies for reducing fertility.

Subsequently, in 1986, the NCDP drafted a national population policy statement for review by the Social and Cultural, and Women's Affairs Committees of the Central Committee of the UNIP. The policy was debated extensively within party and government circles, and in regional seminars throughout the country. Partially as a result of this lengthy review, the policy was not formally adopted until January 1989, when it was issued as part of the Fourth National Development Plan.

The document observes that fertility in Zambia, at 7.2 births per woman, is among the highest in the world. It also notes the adverse impact of the high rate of population growth on the social and

*Like much of Africa, Zambia is a one-party state, and the Central Committee of the United National Independence Party (UNIP) is the most powerful political body in the country.

economic development of the nation and that population growth has consistently outstripped economic growth. The policy reads: "It is, therefore, necessary to achieve a complementarity between the rates of growth of the economy and of the population."[1]

The Zambian policy addresses migration, urbanization, maternal and child health, and high mortality, as well as high fertility and rapid growth rates. The policy calls for sustained measures to reduce the total fertility rate from 7.2 children per woman to 6 by the year 2000 and 4 by the year 2015. This would lower the annual population growth rate from its 1989 level of 3.7 percent to 3.4 percent by 2000 and to 2.5 percent by 2015—still a high rate by historical standards. Nevertheless, the policy statement is far removed from the laissez-faire attitudes of earlier years.

To implement the population policy, the NCDP organized a National Conference on Zambia's Population Policy in May 1989. President Kenneth Kaunda addressed this unprecedented assembly with some remarkably candid remarks about the evolution of population policy. Like many African countries, Kaunda said, Zambia had dismissed the importance of population growth to development in the years following independence.

The reappraisal of population issues in the 1980s, said President Kaunda, had been forced by the growing realization that the rate of population growth had to be commensurate with the social and economic development of the country. Because of dwindling national revenues and the increasing demands of the growing population, Zambia had failed to achieve targeted improvements in the areas of education, health, housing, food supply, employment, and social services. The GDP grew by less than 1 percent per year over the 1980-1985 period, while the population was growing by 3.6 percent annually. The economy recovered somewhat between 1986 and 1988, but economic growth remained lower than the rate of population growth. Living standards continued to decline.

While acknowledging that the policy formulation and adoption processes had been long, even tedious, Kaunda believed the resulting policy was comprehensive, well-articulated, consistent with other national development policies, and respectful of the human rights and the ethnic, religious and sociocultural diversity of the people of Zambia. Implementation of the policy would be a long and arduous journey also, Kaunda said, but he willingly launched Zambia on that path.

Nigeria

Nigeria is the most demographically significant of the sub-Saharan countries. The estimated mid-1989 population of 109 million persons constituted about 21 percent of the entire population of sub-Saharan Africa. At its current annual growth rate of nearly 3 percent, the population would double in 24 years. With such a high rate of growth, Nigeria may well grow to be the third most populous country on earth after China and India.

Despite such powerful demographics, population policy was not a compelling issue in the two decades following Nigeria's independence. There was little information on which to base a serious consideration of the role of demographic factors in development. The last reliable census was taken in 1963 and even that may have been marred by an overcount. Indeed, controversy over the results of the 1963 count may have contributed to the outbreak of civil war.

Nigeria is an outstanding example of a nation created by colonial accident rather than historical evolution. The country has at least 250 different tribal groups and close to 400 separate languages. It is divided as well among Moslems, Christians, and the traditional religions.[2] In 1967, civil war broke out and the Igbo in the East seceded and formed the independent state of Biafra. The civil war lasted three years and took 600,000 lives.

The 1970s brought an economic boom to Nigeria, financed by petroleum. The first oil had been exported from Nigeria as early as 1958 and the sector had grown gradually thereafter. In 1973-74, in the wake of the Arab-Israeli war and the subsequent Arab petroleum em-

bargo, oil prices quadrupled in a single year. Nigerian oil production reached 2.3 million barrels per day in 1974, dropped back to 1.8 million barrels per day in 1978, then surged to 2.4 million barrels per day in 1979. The price per barrel rose dramatically from $2.82 in 1972 to $11.25 in 1974 and then peaked at $38.90 in 1981. The GDP grew by more than 7 percent per year between 1973 and 1977.

The petroleum-driven economic boom muted any concern that population factors might severely limit Nigerian development. Writing as late as 1983, James Kocher, a population expert working in Nigeria, noted the laissez-faire attitude of the Nigerian government towards population issues. He wrote: "because of the oil bonanza and what is generally expected to be a prosperous economic future, most of Nigeria's leaders do not perceive current and projected population growth as a serious obstacle to achieving economic and social objectives."[3]

In the 1980s, world oil demand weakened. Nigeria produced about 2.4 million barrels per day in 1979, but that figure dropped to 1.3 million barrels per day in 1983 and 1984. The asking price for Nigerian crude dropped from $38.90 per barrel in 1981 to $28.00 per barrel in 1984. After further declines, the price rose back to the $15–$16 range.

The drop in world petroleum demand and prices had a devastating effect on the Nigerian economy. The GNP fell by an average of 3.2 percent per year between 1980 and 1986. The GNP per capita fell by more than 6 percent per year over the same time period. Nigerians were also beginning to realize that they did not have the petroleum resources of a Saudi Arabia; rather, oil in Nigeria was a limited resource that would be depleted in about a generation.

The Nigerian Fertility Survey of 1981-1982 revealed a fertility rate of about 6.3 children per woman, suggesting a population growth rate around 3 percent per year. With such high fertility and a rapid population growth rate, Nigeria could anticipate adding more than a 100 million persons to its population in less than 25 years.

In December 1983, Major General Muhammadu Buhari became Head of State in a military takeover; he in turn was replaced by Major-General Ibrahim Babangida in August, 1985. These military governments, well advised by the Ministry of Planning, were soberly aware of the economic realities of the country and attitudes towards population policy began to change. At the International Conference on Population in Mexico City in August 1984, the Nigerian delegation reported: "The Government now recognizes, more than ever before, the fact that the overall rate of growth has to be brought down to the level at which it will not impose excessive burdens on the economy in the long run."[4] By the end of 1984, the government had decided that something had to be done about the high rate of population growth. The task was assigned to the Ministry of Health.

Ministry of Health officials in turn organized an Interministerial Consultative Group on Population and Development, consisting of members from each relevant ministry and major private sector organizations. Health officials sponsored a Plan of Action Workshop for the Interministerial Consultative Group to discuss the magnitude and implications of population growth and the need for a population policy and program and to develop policy recommendations. This Plan of Action Workshop called for the adoption of a national policy to reduce fertility and the rate of population growth and designated a drafting committee to formulate a policy statement.

A policy was drafted and approved by the larger Interministerial Consultative Committee by the middle of 1985. A lengthy but politically necessary process of regional review of the draft policy, as well as internal debate within the government prevented policy from being officially adopted until February 1988. In the interim, the Ministry of Health, the National Population Bureau and other groups developed an extensive awareness campaign in the states on population and development, organized institutional structures for implementation of the policy, formulated a national Family Planning Action Plan, and organized state and LGA (local government

authority) plans for family planning service delivery.

The *National Policy on Population for Development, Unity, Progress and Self-Reliance*, like similar documents, includes sections on mortality, youth, women's status, population distribution, and other basic issues. A fundamental goal of the policy is to achieve lower population growth rates that are compatible with the attainment of national social and economic goals. Lower growth rates are to be achieved by reducing birth rates through voluntary family planning. The primary objectives are to reduce the total fertility rate (estimated at 6.3 to 7.0 children per woman) to a 4-child per woman average by 2000, and to reduce the population growth rate to 2.0 percent per year, also by 2000.

In a few short years during the economically turbulent 1980s, Nigeria was transformed from a country where the leadership was generally indifferent to population matters, to one holding an official policy and supporting programs to reduce birth rates and population growth rates.

Zaire

Zaire is not a likely leader in setting population policy in sub-Saharan Africa. The country encompasses more than 2.3 million square kilometers (about twice the size of West Germany, France, Italy and Switzerland combined) and had an estimated mid-1989 population of 34.9 million persons. In a 1982 study, the Food and Agricultural Organization indicated that Zaire has enough land to feed upwards of 300 million persons on a sustained basis, even using subsistence agriculture technologies.

Nonetheless, Zaire has followed the pattern of other African nations in the development of a national population policy. Again, economic factors are at the center of evolving attitudes. Between 1965 and 1986, the World Bank estimates that the GNP per capita fell by an astonishing 2.2 percent per year. In 1987, GNP per capita was only $160, placing Zaire among the four poorest countries on earth.

In this historical context of high population growth rates and economic decline, a number of factors and events contributed towards the crystallization of a national population policy. Several are mentioned below.

A few foundation blocks for constructing a national population policy existed prior to the 1980s. Family planning began in Zaire in the early 1970s with the *Naissances Desirables* (Desired Births) program. In the early 1980s, this program became affiliated with and received funding from the International Planned Parenthood Federation. Additional funds for family planning were sought from international donors. The University of Kinshasha, Zaire has long had active academic programs in demography.

The Second African Population Conference in Arusha in 1984 and the Mexico City Conference later the same year contributed much to population thought in Zaire. In June 1985 the government held a seminar on the preliminary results of the 1984 census, which confirmed the status of Zaire as a high fertility, rapidly growing country. The *Departement du Plan* (Ministry of Planning) presented a microcomputer simulation model showing the impact of population growth on development at this meeting.

Representatives from the same Departement du Plan, attending a workshop held in conjunction with the All-Africa Parliamentary Conference on Population and Development held in Harare in 1986, reported that Zairian leaders were convinced of the importance of developing a national population policy and were ready to act. Also, in June 1986, the Departement du Plan held a second seminar on population and development planning which succeeded in convincing senior officials of the need for a national population policy. Much of the impetus from this seminar had come from the ILO Regional Population Officer who was working towards the development of a Population and Development Planning Unit to be funded by the United Nations Fund for Population (UNFPA).

The Departement du Plan was also instrumental in calling for the creation of a National Population Committee (CONAPOP), to formulate a national policy. CONAPOP consists of representatives of several ministries, religious

groups, the Demography Department at the University of Kinshasha, the local International Planned Parenthood Federation affiliate and others. Departement du Plan staff demonstrated microcomputer models on population and development to the Prime Minister, the Council of Ministers and other ranking leaders in the country, and helped organize a trip to Nigeria to observe the policy formulation process in that country.

In culmination of these efforts, the government held a five-day working meeting with representatives from all the ministries and the principal private organizations to discuss the formulation of a national population policy. As the meeting closed, a group of seven experts from the ministries and the university met to draft the policy.

The resulting *Politique Nationale de Population au Zaire* is a comprehensive statement on population policy in the country, addressing mortality and migration as well as fertility. The stated basic objective of the population policy is to raise the quality of life of Zaire's citizens by bringing population growth into equilibrium with economic growth. The policy document recognizes the detrimental effects of Zaire's high population growth rate on public health and on social and economic development, especially given the long history of poor economic performance. The policy calls for increasing contraceptive prevalence from its present level to 10 percent by the year 1990 and to 33 percent by the year 2000. In addition to the policy, Zairian officials prepared a detailed set of implementation action plans.

The policy was adopted by the National Population Committee and sent to the Executive Council (cabinet) in mid-1989 for approval. In the council, the approval process was stymied. Many of the *commissaires* (ministers) were relatively new and had not been involved in the lengthy policy formulation process. They returned the policy to the National Population Committee asking for numerous clarifications. In October 1989, the National Population Committee was still preparing responses for the Executive Council, but hoped to resubmit the policy in the near future.

Liberia

The West African country of Liberia, with 2.5 million inhabitants in mid-1989, has historical ties to the United States. Liberia was founded in 1822 by the American Colonization Society as a haven for freed slaves. The members of the American Colonization Society were opposed to slavery, but were also reluctant to have the freedmen settle in North America. In 1847, the country became the independent Republic of Liberia.

The development of a national population policy has followed a pattern in Liberia similar to that elsewhere on the continent. Liberia took national censuses in 1962 and 1974, and then again in 1984. National demographic surveys were taken in 1969, 1972, 1978, 1979, and 1986. Collectively, these surveys and enumerations presented a picture of a country with a high fertility rate and a population growth rate exceeding 3 percent per year. The population had doubled in size—from 1,016,443 to 2,101,628—between the 1962 and 1984 Censuses.

While Liberia's population continues to expand, the country's economic misfortunes have grown. Over the 1965-1980 period, the gross domestic product (GDP) increased by an annual average of 3.3 percent, very close to the yearly rate of population growth. Consequently, GDP per capita changed little. Between 1980 and 1986, the GDP actually dropped by 1.3 percent per year, sending per capita income into a sharp decline.

The setting was ripe for a re-evaluation of population policy in Liberia. An initial event in Liberia's population policy evolution was a U.S. Agency for International Development-sponsored analysis on the long-term implications of the rapid rate of demographic growth for the social and economic development of the country. A corresponding series of presentations and discussions with ranking political leaders helped to crystallize Liberian thought on population issues.

Subsequently, the Liberian Ministry of Planning established a National Committee on Population Activities composed of 15 members from key ministries and se-

lected private organizations. In 1984, this committee produced an important document, *Liberia: Towards Population Policy Formulation*, which argued that the rapid population growth was impeding the social and economic development of the country. It called for lower growth rates to be attained through the expansion of voluntary family planning and maternal and child health programs. This preliminary document also emphasized the need to improve educational opportunities for women and to improve living conditions in the countryside to stem the high level of rural-urban migration, especially to Monrovia.

The National Committee on Population Activities subsequently sponsored a number of population conferences and media awareness programs on population and development. In September 1986, the government established the Population Commission for Liberia to develop a national population policy. The organization was composed of 21 members from selected government ministries and other private organizations. A national population policy was drafted by February 1987; President Doe endorsed it and sent it to the legislature in September of the same year; and the Population Commission disseminated the draft policy to the public through a variety of media during a National Population Week the same month. In July 1988, the policy completed the presidential and legislative approval processes and was enacted into law.

As with many of its counterparts in other nations, the population policy is detailed in a comprehensive document which includes a rationale, objectives, and strategies for implementation in several key areas: maternal and child health; family planning; the role of women in development; population programs for children and youth; population education and information; rural-urban migration; and data collection, research, and training.

The economic underpinnings of the policy are openly stated: "The goal of the population policy in regulating fertility and reproduction should be to reduce total fertility in order for population growth to correspond with the socioeconomic growth of the nation."[5] The policy calls for greatly expanded family planning services to increase contraceptive prevalence to 50 percent of couples of childbearing age by the year 2000, and to reduce the total fertility rate from 6.7 to 4 children per woman over the same period of time.

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Population Policies in the 1980s

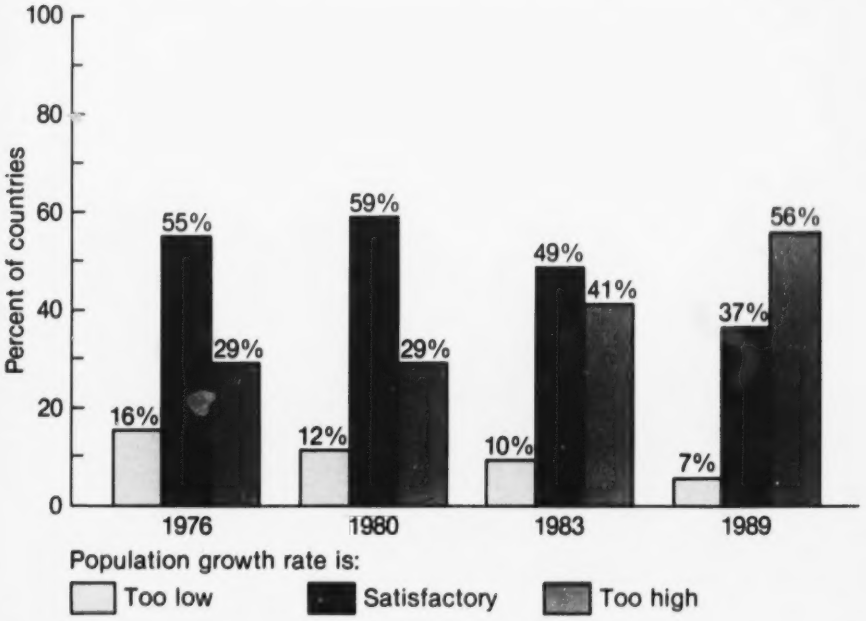
At the noted 1974 World Population Conference in Bucharest, the only sub-Saharan African nations with official policies to reduce population growth to aid development were Kenya and Ghana (and the Indian Ocean island nation of Mauritius). Even these policies were mainly rhetoric. Kenya launched a family planning program to reduce fertility in 1967, the first government program in the region, yet it received little real support. After 1967 Kenyan President Jomo Kenyatta never again mentioned the population program.

Most of sub-Saharan Africa entered the 1980s with lukewarm attitudes towards developing population policies and programs. Yet at the end of the decade, a new, much more favorable environment exists throughout much of the region for the development of population policies and family planning programs designed to reduce birth rates and population growth rates for development purposes (see Figure 6).

Contributing Factors

During the 1980s, an unprecedented amount of scientific information documenting fertility levels, rates of population growth, and the sizes of national populations began to reach high level

Figure 6. Changes in Government Perception of Population Growth Rate, Sub-Saharan Africa, 1976 to 1989



Source: UN Secretariat. Population Policy Data Bank, Population Division, Department of International Economic and Social Affairs.

government leaders.

Many African nations had their first or second censuses during the 1970s and early 1980s. These enumerations identified not only the size of the population but also fertility levels and rates of growth. The World Fertility Survey, which included 10 sub-Saharan nations between 1977 and 1982, and its successors, the Contraceptive Prevalence Survey and Demographic and Health Survey programs, and numerous special surveys provided copious data on childbearing practices and on contraceptive knowledge and attitudes among African women.

The message which emerged from this data was almost invariable: national populations were larger than previously estimated; fertility rates were among the world's highest and in many cases had been rising rather than declining; and population growth rates were the highest in the world. Nearly all the national populations in the region were on a pace to double in size within 25 years.

A series of major international conferences on population have helped to crystallize African thinking on the subject. Foremost among these was the Second African Population Conference held in Arusha, Tanzania in 1984, a prelude to the International Conference on Population held in Mexico City later that year. Both conferences were sponsored by the United Nations. The All-Africa Parliamentary Conference on Population and Development, held in Harare, Zimbabwe in 1985, also influenced political thinking.

These conferences stimulated governments to formulate official positions on population. The results are reflected in the Kilimanjaro Programme of Action on Population which emanated from the Second African Population Conference. The conferees recommended that population should be seen as a central component in formulating and implementing policies and programs for accelerated socioeconomic development plans; that government-subsidized family planning services should be made available at no or a low cost to all couples or individuals seeking such services.

Recommendations from international conferences are not in any way binding on government leaders back home. But the Arusha meeting was legitimately a seminal event in the formulation of population policies in sub-Saharan Africa which did much to spur and define the content of later national discussions.

Economic Stagnation

But, of course, it has been more than an increased awareness of population trends which has contributed to changing attitudes towards population programs. Rather, high population growth rates *in combination with* a stagnating social and economic development effort provided the catalyst for a reevaluation of the role of population factors in development.

The region's economic problems during much of the 1970s and 1980s have proven long-term, deep-seated and recalcitrant. Nor are prospects for the near future especially bright. For example, the World Bank projects that there will be no increase in gross domestic product (GDP) per capita over the 1987—1995 time span in the sub-Saharan region. Even under optimistic projections, GDP per capita would increase by only 0.7 percent per year over the 1987–1995 period. With declining or stagnating incomes, per capita expenditures on health, education and other services have also dropped.[50]

Other Factors

Other factors have also contributed to the evolution of population policies in the sub-Saharan region. Population expert Linda Lacey observes that concern over high levels of maternal and infant mortality have been factored in the decision to pursue population policies, especially among health officials, women's organizations, and religious leaders. She also notes that the activities of pioneering private family planning associations helped demonstrate the demand for services and the ability to overcome opposition.[51]

Prospects for Fertility Decline

The changing population policy environment in sub-Saharan Africa has stimulated an intense discussion about the prospects for fertility decline in the region. Some are worried that the rhetoric of the new policies has not been matched by action. Fred Sai is concerned that African governments are not giving new family planning programs high enough priority or adequate funds and that they are too often placing these activities under mediocre leadership.[52] Some observers suggest that the demand for family planning services is too small to bring about rapid fertility decline even if programs were strengthened. Others see possibilities for significant fertility decline during the decade of the 1990s.

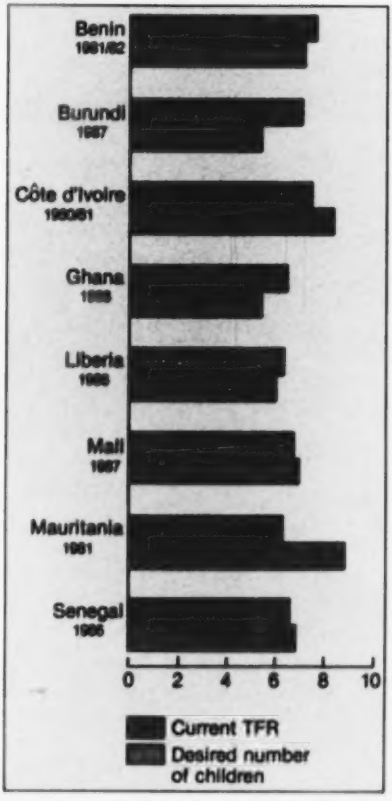
Desire for Large Families

The fertility rates are not likely to fall until African couples decide to limit the size of their families. Yet all the evidence suggests that they have many children because they want them. The ideal family size among Africans ranges from 5.3 to 8.8 children, according to survey data from late 1970s to 1989. In some countries women are having fewer children than they would like (see Figure 7).

For most countries, the average desired family size was higher than or about the same as the fertility rate. In Senegal (1986), desired family size was 6.8 children per woman while actual fertility was 6.6. In Liberia (1986), desired family size was 6.0; actual was 6.3.

Historically, desired family size (and consequently, actual fertility) has fallen as development progresses. Based on experience of the developed world and developing countries like [illegible]ea, Singapore, and Hong Kong, it seemed that industrialization, a high proportion of urban dwellers, and relatively high per capita incomes were prerequisites for fertility decline. Now it has been shown that fertility can decline markedly in countries where the economy is not yet highly industrialized, per capita income is low, and the population is still largely rural: China, India, Indonesia, Thailand, and Sri Lanka. Recent fertility declines have been associated less with per capita income levels than with improvements in life expectancy, female education, and a relatively equitable distribution of income and access to services (including family planning).[53]

Figure 7. Desired Number of Children and Estimated TFR: Selected Sub-Saharan Countries



Source: World Fertility Survey and DHS Reports

Cultural Determinants versus Family Planning

Many experts argue that the strong cultural and economic underpinnings of high fertility in Africa are impervious to change in the near future. The demographic implications of the cultural determinants position are perhaps best summarized by John and Pat Caldwell: "But in this century there will be no declines like those of Asia, and fertility will probably remain above even the seemingly cautious World Bank standard projection. That projection shows the crude birth rate for the entire region falling from the current level of 47 per thousand population to around 40 in the year 2000. We feel that it might not fall much below 45 in the absence of a radical change in government attitudes towards family planning programs. . . ."[54]

Other observers see evidence of an increasing demand for family planning services across the continent and with it the seeds for fertility decline. Cultures are not immutable; they change, often rapidly in the modern world. In the changing environment of contemporary Africa may be found a surprisingly large unmet demand for family planning services. Several factors suggest an unmet demand for family planning: increasing prevalence of abortion; the growing practice of child-dumping, the abandonment of infants and children in the urban centers; and the strong desire among women to avoid pregnancy in the postpartum period.

Proponents of this position argue that family planning services in sub-Saharan Africa are so weak that current contraceptive prevalence figures cannot truly reflect the actual demand. Only when high quality services are widely available can the real demand for services be judged. Though the cultural determinants are strong, when good services are in place, women seem to use them and overall contraception increases significantly. The classic 1986 World Bank policy study *Population Growth and Policies in Sub-Saharan Africa* reported: "In Chogoria, Kenya, a rural area of 200,000 people where a pilot program provides easily accessible health and family planning services and careful follow-up, about 27 percent of couples use modern contraception, compared with roughly 8 percent for the country as a whole. In a rural project in Zaire the contraceptive prevalence rate (for modern methods only) is roughly 25 percent, against an average of 3 percent for Zaire as a whole. Even at the national level, [Zimbabwe and Botswana are cited as examples] when programs are strong, prevalence rates are high. . . ."[55]

There appears to be an unmet demand for contraception even among the poor. Survey results suggest that a certain proportion of African women, up to 10 percent in some countries, want no more children but are not using any form of contraception. An even larger proportion of women would like to have longer intervals between pregnancies. Furthermore, although overall desired family size remains high in Africa, it is lowest among women aged 15-24, urban women, and women with a primary or higher education. If the actual fertility of these women over time corresponds with their present intentions, contraceptive use should rise and fertility should fall.

The World Bank suggests that a contraceptive prevalence rate of 25 percent for sub-Saharan Africa could be reached over the 1986–1996 decade. Africa's contraceptive prevalence rate of about 4 percent has resulted in birth rates in the 45-50 per 1,000 range. A 25 percent contraceptive prevalence rate could lower rates to the 35-40 range, and consequently, reduce the annual rate of population growth by more than an entire percentage point.

Even if demand is as high as believed, services and information programs have to be put into place to meet it. The mostly new family planning programs in the sub-Saharan region lack resources, adequately trained staff, good management, and infrastructure. The political will to di-

rect adequate resources towards these programs is still weak. The World Bank indicates that just to meet the goals in its medium or standard projection (see below), annual expenditures on family planning would have to rise from under $100 million in the mid-1980s to $640 million in 2000 and $3.2 billion in 2030 (in constant 1984 U.S. dollars). Rapid expansion of existing family planning programs will not be easy.

Two significant issues in this debate are, first, a sense of the relationship between contraceptive prevalence and fertility decline, and, second, an appreciation of the importance of the timing of the onset of any fertility decline for the demographic future of the continent.

Achieving Initial Declines

Demographers John Bongaarts and Odile Frank estimate that—in most populations—fertility can then be expected to decrease about 0.62 births per woman, on average, for every 10 percent increase in contraceptive prevalence. Replacement level fertility, which is slightly over a two-child per woman average, would thus require a prevalence rate of about 75 percent.[56]

But the pattern in Africa has not been consistent with these findings. In Zimbabwe, for example, a 1984 fertility survey showed that 27 percent of the married women of reproductive were using some form of modern contraception and another 11 percent were using a traditional method. The fertility rate should have been about 4.5 children per woman; in actuality, it was closer to 6.5 children per woman.[57] In Kenya, the fertility rate remained high, and possibly even rose, between the early 1960s and late 1970s, at the same time that contraceptive prevalence rose from virtually zero to about 7 percent of the married women of reproductive age. In other parts of Africa, fertility is likely to rise in the future. Economist James Knowles, for example, writes that fertility in Zaire is probably going up and that just maintaining present fertility levels until the year 2000 would be an acceptable policy goal.[58]

In Africa, cultural factors can offset the increased use of contraception. In particular, many African tribes have traditionally practiced lengthy periods of postpartum abstinence from sexual relations, ranging from a few months to close to three years. In some cases, the new mother returns to her mother's home for a lengthy stay to care for her baby. With urbanization and modernization, this practice has been decreasing in contemporary Africa. Many women no longer accept the notion that intercourse harms the mothers milk and they are increasingly disinclined to accept the sexual competition which comes with prolonged abstinence.[59] The decline in postpartum abstinence increases the time a woman is at risk of pregnancy and inevitably the fertility rate as well. And insofar as contraceptive use is a substitute for prolonged abstinence, the net impact on fertility levels will be minimal.

Breastfeeding of infants is almost universal in much of Africa. Because lactation suppresses ovulation, extended breastfeeding also serves to reduce the risk of pregnancy. However, the practice is declining in both frequency and duration, which contributes to even higher fertility in the absence of increased contraceptive use.

In addition, health practices, especially among women with some primary education, have probably improved enough over the past two decades to reduce levels of pregnancy wastage, so that a larger proportion of pregnancies result in live births.

Much of the limited demand for family planning services that currently exists in Africa appears to be motivated by a desire to avoid premarital or extramarital pregnancies and to substitute contraception for postpartum abstinence; the motivation is much less often to limit family size.[60] Contraceptive use for these purposes has a minimal effect on overall fertility.

Hence, at the outset of Africa's transition from high to lower fertility, there is no direct connection between contraceptive prevalence and fertility. As family planning programs expand in Africa, they are not nec-

essarily going to result in immediate fertility decline; indeed, fertility may actually rise in the short term. If contraceptive use continues to rise, however, fertility levels will invariably begin to fall. The erosion of traditional breastfeeding and abstinence practices, as well as other mechanisms for childspacing, argues for the expansion of family planning services.

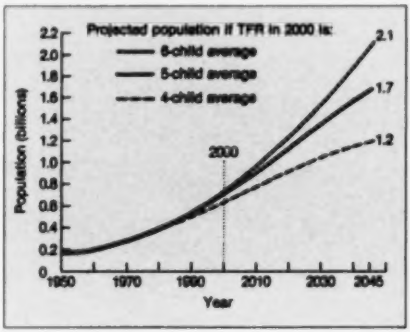
That an unmet demand for family planning services exists in sub-Saharan Africa is clear. However, the existence of this demand can often catch observers in a "looking up–looking down" trap. For example, if prevalence rates for modern contraception rose from their present levels of about 4 percent to 14 percent by 2000, then about 22 million women would be using modern contraception—five times the number in the 1980s. Many observers effusively insist that African women are "ready" for family planning, that the demand for services exists.

Yet, as suggested from the above analysis, were one "looking down" from the encompassing perspective of overall demographic trends, the picture would appear different. An increase to a 14 percent prevalence rate by the year 2000 would have only a minimal impact on fertility levels and population growth rates would remain very high. The rapid expansion of family planning service systems in the sub-Saharan region will not necessarily mean significant fertility decline, especially in the near term.

The Timing of Fertility Decline

The timing of the fertility decline is crucial. The question is not whether African fertility is going to decline; it inevitably will. Indeed, historians may well decide that fertility was already beginning to decline in the late 1980s. The more useful question is: Will fertility decline in the near future be substantial enough to affect significantly population growth rates over the next 10 to 15 years?

Figure 8. Timing of Fertility Decline and Future Growth, Sub-Saharan Africa



Source: World Bank, 1986.

The 1990s are truly critical for the demographic and the development future of Africa. The extent and pace of fertility decline over this decade, if any, will have a radical impact on the future. If the total fertility rate (TFR) remains above 6 until the year 2000, the sub-Saharan population could reach 2.1 billion by 2045, according to World Bank projections. If it drops to 5.2 by the end of this century, the 2045 population would be nearly one-half billion lower (see Figure 8). If the TFR drops closer to a 4-child per woman average by 2000, the population in 2045 would be 1.2 billion persons. The difference between the high and low projections equals almost 900 million persons by 2045, or about double the 1985 population size of the sub-Saharan region.

No doubt exists that there is an unmet demand for family planning services in Africa and that this demand will increase over time. But the cultural underpinnings of high fertility in sub-Saharan Africa remain powerfully strong and change slowly. The ability to expand family planning programs rapidly is limited, and in a time of economic malaise, the competition for scarce resources is intense. And many African governments still have to commit themselves unequivocally to lower rates of population growth as a fundamental com-

ponent of social and economic development. Yet, African countries have achieved much with limited resources in the past—for example, the rapid expansion of primary school enrollments in the post-independence period—and the beginnings of a transition to a new regime of demographic behavior may already exist.

Policy Options

Practical measures to reduce birth rates, especially in rural Africa, can be divided into four areas: (1) measures to help create a demand for smaller families; (2) measures which contribute to a widespread social acceptance of family planning; (3) programs which actually extend family planning services; and (4) activities which affect the cultural or economic determinants of fertility, especially age of marriage and breastfeeding.[61]

Creating a Demand for Smaller Families

Social and economic change is undoubtedly central to any hope of increasing demand for smaller families and achieving fertility reduction. Lower infant and child mortality rates, rising and more equitably distributed incomes, higher levels of education, more economic and social opportunities for women, and greater security would all serve to provide a climate more conducive to fertility decline. Of these, increased educational and economic opportunities for women may have the greatest effect.

Promoting Family Planning

An important component of policy activities in Africa will be to make couples aware of means to control fertility and to make it socially acceptable to use these methods—what the World Bank terms building a consensus on the legitimacy of family planning. Information programs should (1) emphasize the benefits of family planning, both in terms of the health of mothers and children and the social and economic development of the region; and (2) describe alternative contraceptive methods, how to use them, and where to obtain them. Information is also needed on the advantages of breastfeeding and longer birth intervals.

To build the needed consensus, information should be aimed at current and potential family planning users and at political and community leaders, such as traditional chiefs, parliamentarians, religious leaders and senior medical personnel. The mass media and the schools can also be used to deliver population messages to more general audiences. As the social acceptance of family planning increases, the opportunities to achieve higher prevalence rates and lower fertility will be enhanced.[62]

Expanding Family Planning Services

Family planning programs to provide modern contraceptive methods have been instrumental in reducing fertility rates in other developing regions. Family planning services can be delivered through a number of mechanisms. Some government programs integrate services in maternal and child health or basic health care programs. In these programs, family planning is offered at clinics or health posts that also provide other health services.

In Africa, family planning services are rarely fully integrated into the health system. In other parts of the developing world, freestanding clinics which provide only family planning and related services have been used; however, given the poor condition of other health services, it is unlikely that extensive freestanding systems will be developed in Africa.

Zimbabwe does use a separate family planning system but utilizes an extensive network of outreach workers who visit clients in the *kraals* and villages. The Zimbabwean community-based distribution approach has been relatively effective for the African setting but it is comparatively expensive and may be difficult to emulate in other countries.

While private and commercial efforts

can reach a significant proportion of the population in urban areas, government programs will be necessary to expand family planning services into rural Africa where most people live. This will probably be achieved by grafting family planning services on the present health infrastructure rather than developing independent family planning delivery systems.

National family planning associations are the most active and prominent nongovernmental providers of family planning services in Africa. At least 25 countries in the region now have national family planning associations which are affiliated with and receive support from the International Planned Parenthood Federation (IPPF), a nonprofit, nongovernmental organization based in London. Many of the national family planning associations work in close conjunction with their governments.[63] The Uganda Family Planning Association, for example, often uses Ministry of Health facilities for its clinics and, in fact, provides government family planning services.

Women's groups, churches, unions, private physicians and other groups also help deliver family planning services in various parts of Africa. Taken together, they are potentially an important source of services. In other parts of the developing world, employers in factories and on plantations have been encouraged to include family planning as part of their institutional health care program. This approach is also now being used in Africa. For example, major oil companies in Nigeria have taken a lead in providing family planning services to employees. Large employers, however, engage only a small proportion of the African labor force and this approach by itself is likely to have only a minimal effect on fertility.

Social marketing of contraceptives is being introduced in some African countries. Social marketing groups or governments provide contraceptives, most often pills or condoms, at subsidized prices to pharmacists and other distributors who in turn are allowed to sell them for a profit. The price is kept low enough to keep the products accessible to low- and middle-income groups.

The commercial distribution of contraceptives through social marketing has certain advantages in the African context. An extensive network of shops and pharmacies already exists in most countries. Use of the private sector permits contraceptive distribution while bypassing sometimes cumbersome and inefficient public bureaucracies.

At the same time, social marketing tends to be more successful in urban areas and less so in rural regions. For the most part, social marketing programs seem to have been most successful in countries which have already started the demographic transition towards lower fertility; how they will fare in poor, high fertility African nations just beginning a demographic transition is an unknown.

Most of the social marketing programs in the sub-Saharan region—in Zimbabwe, Ghana, Nigeria, and elsewhere—are new and their impact cannot yet be evaluated. The Ghana program appears to have helped increase condom use. However, condoms are often used in urban areas from fear of sexually transmitted diseases and AIDS and not directly for family planning.

Delaying Marriage, Promoting Breastfeeding

In other world regions a rise in women's average age at marriage helped reduce fertility even when desired family size is high. While legislation to raise the legal marriage age would be difficult to enforce in sub-Saharan Africa, rewards, such as increased schooling opportunities, could be offered to women who delay marriage.

A few countries have raised the minimum age for marriage. In Togo, girls may not marry before age 17 and in Côte d'Ivoire, age 18. The importance of marriage age was recognized by national leaders at the Second African Population Conference, who resolved that "national programs, especially in education,

USAID Dolores Weiss
A Liberian girl studies her lessons. Girls who stay in school are more likely to delay marriage.

should aim at raising the age at marriage."[64]

Breastfeeding, which reduces fecundity, is now declining in urban and some rural areas. Governments could counter this trend by providing information to mothers on the contraceptive effects of breastfeeding, as well as its important role in infant survival.

Other Program Issues

If a variety of family planning service delivery alternatives must be tried, so too must a "cafeteria" of alternative contraceptive methods be made available. Oral contraceptives (pills) are by far the preferred alternative among current users of modern contraception. Pill use requires a consistent monthly pattern which may constrain their use among illiterate, rural populations. Injectibles, especially Depo-Provera, are popular because they provide three months of protection with a single shot. However, Depo-Provera is not approved by the Food and Drug Administration for use in the United States which makes its use in developing countries controversial. Intrauterine devices (IUDs), popular in some Asian programs, are not widely used in Africa. Other female methods, such as diaphragms or foaming tablets, are often difficult to use hygienically in African settings and are not popular. Condoms have not been used much until recently when increased fear of AIDS and sexually transmitted diseases spurred a surge in use. Male or female sterilization, an important component of some successful Asian programs, is negligible in Africa. Some observers believe that sterilization is so inimical to African values and cultural beliefs that it cannot play a significant role in the newly emerging programs.

Because of the limited demand, the weakness of family planning programs operating so far, and the traditional social and economic milieu, African leaders insist that great sensitivity must be shown in implementing programs. Fred Sai argues: "The only way to have meaningful population and family planning programs is to put the programs firmly within people-oriented development programs and activities."[65]

There is agreement on one issue in country after country, even among those most worried about high birth rates: programs must be strictly voluntary. Most experts agree that any measures that even imply coercion must be rejected, not only because they would be contrary to African cultural values but also because they could discredit the programs.

Conclusion

"At no time in history," reports the World Bank, "has any group of nations faced the challenge of development in a situation of such rapid population growth."[66] In combination with stagnating economies, this imposing demographic reality has led African governments to consider and in some cases adopt new policies designed to reduce high fertility and high population growth rates. The 1990s will test the depth of this political commitment, as well as the practicable ability to implement new programs, increase contraceptive prevalence, and lower birth rates. Passage of this challenge will be one important factor determining whether a new Africa can emerge in the 21st century, one free from hunger, disease, illiteracy, unemployment, and poverty.

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Discussion Points

1. Discuss the challenges that countries of sub-Saharan Africa face as they modernize. How do their challenges compare to those countries that modernized earlier (i.e. Japan and the U.S.)?

2. Outline the demographic changes experienced by sub-Saharan Africa in the past 30 years. (Consider birth rate, death rate, natural increase, life expectancy, infant mortality, etc.) Compare sub-Saharan Africa to Latin America today and to Latin America 25 years ago.

3. Discuss the prospect for population growth in sub-Saharan Africa. How will AIDS affect future population growth in the region and in particular countries?

4. How is the transmission of AIDS in Africa different than in other parts of the world? Are Africans more susceptible to the disease? If so, why?

5. It is often said that rapid population growth is the cause of declining per capita food production in Africa. Do you agree?

6. What are some of the push and pull factors associated with rural-to-urban migration in sub-Saharan Africa? Are migration patterns in Africa similar to those in other regions?

7. Sub-Saharan Africa now has the highest fertility in the world. Describe some of the factors that work to keep fertility high in this region. What are the prospects for fertility decline?

8. How do families and communities support large families? What are some of the positive and negative results of these practices?

9. Why have African leaders changed their views on population growth? Review the development of population policies in the 1980s.

10. How do the policy options described by the author incorporate improvement in women's status?

Prepared by Kimberly A. Crews

Africare

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